

AUTHORIZATION TO RELEASE AND ASSIGN BENEFITS

Patient Name: _____ Date of Birth: _____

I authorize Aspirus Cardiovascular Associates to disclose to my insurance carrier, information from the Clinic/Hospital records relating to my identity, diagnosis, prognosis or treatment. I understand that the purpose of this disclosure is to facilitate payment of insurance benefits.

I hereby assign benefits from my insurance carrier to Aspirus Cardiovascular Associates.

I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to Aspirus Cardiovascular Associates.

This authorization will remain in force and effective until I choose to revoke it.

Patient/Authorized person signature

Date