Main Line HealthCare

Chestmont Neurosurgical

Bryn Mawr Hospital Health Center

3855 West Chester Pike, Suite 245, Newtown Square, PA 19073

610-325-3880 • Fax: 610-325-3887

RELEASE AND ASSIGNMENT Date:_____

To: _____

INSURANCE COMPANY

_____

Group No. _____ Certificate No. _____

I hereby authorize Dr. _____ to release to your company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care.

I also authorize and request your company to pay directly to the above named doctor the amount due me in my pending claim for Basic Medical, Major Medical and/or Surgical treatment or services by reason of such treatment or services rendered to:

_____

PATIENT

_____

SIGNATURE OF INSURED

_____ _____

WITNESS ADDRESS