CAPS PAINCARE
Phone: 888-CAPS-313 / 888-227-7313
Fax: 708-632-5602
Email: appt@capspaincare.com
www.capspaincare.com

RELEASE OF MEDICAL RECORDS AGREEMENT

LEGAL ASSIGNMENT OF BENEFITS & RELEASE OF MEDICAL RECORDS

In considering the amount of medical expenses to be incurred, I , the undersigned, have insurance and/or employee health care benefit coverage and hereby assign and convey directly to Chicagoland Advanced Pain Specialists, Inc. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered at your office from your doctor(s). I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize doctors, any plan administrator, fiduciary, insurance company, and my attorney to release to such doctor and office any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and office in order to claim such medical benefit, reimbursement, and any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits for claim submissions.

I hereby convey to the above named doctor and office to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan, any claim, chose in action, or other right I may have to such insurance and/or employee health care benefit coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above office/doctor and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and office in any attempts by doctor and office to pursue such claim, chosen in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and office against such insurer and/or employee health care plan in my name but a doctor and office expense.

This assignment will remain in affect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

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Signature of Insured/Guardian Date