ARLENE M. WEINSHELBAUM, M.D.
GAINESVILLE WOMEN'S CENTER FOR RADIOLOGY
6820 N.W. 11th PLACE
GAINESVILLE, FLORIDA 32605-4217
PHONE (352) 331-0115
FAX (352) 331-2044

MAMMOGRAPHY
ULTRASOUND
BONE DENSITOMETRY
STEREOTACTIC BREAST BIOPSY
ULTRASOUND GUIDED BREAST BIOPSY
CHEST RADIOLOGY

DIPLOMATE AMERICAN BOARD OF RADIOLOGY
MEMBER AMERICAN COLLEGE OF RADIOLOGY

INSURANCE AUTHORIZATION/RELEASE FORM

RELEASE INFORMATION: I, the below named patient, do hereby authorize any physician examining and/or treating me to release any third payor such as an insurance company or governmental agency, (example: Blue Shield of Florida or Medicare) any medical and psychiatric information and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for treatment and/or diagnosis.

PHYSICIAN INSURANCE ASSIGNMENT: I, the below named subscriber, hereby authorize payment directly to any physician (examining or treating me) of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

MEDICARE/MEDICAID: Patient's certification authorization to release information and payment request.
I certify that the information given by me in applying for payment under Title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration Division of Family Services of its intermediates or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

*I PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.

*I AGREE THAT SHOULD THE AMOUNT OF THE INSURANCE BENEFITS BE INSUFFICIENT TO COVER THE EXPENSES, I WILL BE RESPONSIBLE FOR PAYMENT OF THE DIFFERENCE. I WILL BE RESPONSIBLE FOR THE ENTIRE AMOUNT DUE FOR PROFESSIONAL SERVICES RENDERED IF THE EXPENSES ARE NOT COVERED BY MY POLICY.

SIGNATURE_____ DATE_____
(Patient, policy holder or responsible party-relationship)