

SOUTH CHARLESTON CARDIOLOGY ASSOCIATES, PLLC

PATIENT AUTHORIZATION

I authorize any holder of medical or other information about me to release it to South Charleston Cardiology Associates, PLLC, the Social Security Administration, or any other insurance carriers that may be needed to process and pay this or any related claim. This shall also serve as authorization for South Charleston Cardiology Associates, PLLC to release any medical or other information about me to other parties in order to assist in the management of my health care, payment of claims, and/or disability claims. I permit a copy of this authorization, as well as the phrase "Signature on File", to be used in place of the original. Also, I request payment of benefits to be made to South Charleston Cardiology Associates, PLLC. I understand that South Charleston Cardiology Associates, PLLC is only acting on my behalf and they cannot guarantee coverage, much less payment. I agree to pay the balance in full or making payments with the Accounts Receivable Department.

Patient's Signature

Date

Witness Signature

Date

KANAWHA VALLEY RADIOLOGISTS, INC.

PATIENT AUTHORIZATION

I authorize any holder of medical or other information about me to release it to Kanawha Valley Radiologists, Inc., the Social Security Administration, or any other insurance carriers that may be needed to process and pay this or any related claim. This shall also serve as authorization for South Charleston Cardiology Associates, PLLC to release any medical or other information about me to other parties in order to assist in the management of my health care, payment of claims, and/or disability claims. I permit a copy of this authorization, as well as the phrase "Signature on File", to be used in place of the original. Also, I request payment of benefits to be made to Kanawha Valley Radiologists, Inc. I understand that Kanawha Valley Radiologists, Inc. is only acting on my behalf and they cannot guarantee coverage, much less payment. I agree to pay the balance in full or make payments with the Accounts Receivable Department.

Patient's Signature

Date

Witness Signature

Date