

**SIERRA CARDIOLOGY MEDICAL ASSOCIATES**  
Practice Limited to Cardiovascular Diseases

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_  
MAILING ADDRESS: \_\_\_\_\_ P.O. BOX: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ SEX: \_\_\_\_\_  
SOCIAL SECURITY #: \_\_\_\_\_ DRIVER'S LICENSE #: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
EMPLOYER ADDRESS: \_\_\_\_\_  
IN CASE OF EMERGENCY, CONTACT: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
PRIMARY INSURANCE CO.: \_\_\_\_\_  
SECONDARY INSURANCE CO.: \_\_\_\_\_  
SPOUSES NAME: \_\_\_\_\_

**ASSIGNMENT AND RELEASE:**

I assign directly to Sierra Cardiology Medical Associates all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and coordinate care with other physicians and health care providers. I authorize the use of this signature on all my insurance submissions. This release is considered valid until revoked by me in writing.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

**RECORDS RELEASE AUTHORITY**

TO: \_\_\_\_\_  
I authorize you to release to Sierra Cardiology Medical Associates to coordinate my cardiac care including, but not limited to, reports of ECG, echocardiogram, treadmill, cardiac catheterization, nuclear medicine studies, coronary bypass and PTCA procedures, pacemaker operative reports and follow-up discharge summaries/progress notes.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date