SOUTHERN WESTCHESTER ORTHOPEDICS & SPORTS MEDICINE ASSOCIATES, P.C.
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NEW YORK NO FAULT MOTOR VEHICLE INSURANCE ASSIGNMENT OF INSURANCE BENEFITS

NAME OF PHYSICIAN PROVIDING HEALTH SERVICES: ______________________________

PATIENT'S NAME AND ADDRESS: ______________________________

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DATE OF ACCIDENT: ______________ FILE OR POLICY # ______________

NAME OF INSURANCE COMPANY: ______________________________

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NAME OF INSURED: ______________________________

I authorize release of any medical information to my Primary Care Physician and/or insurance company. I also certify that I have read and have been given a copy of Southern Westchester Orthopedics & Sports Medicine Assoc., P.C.'s Notice of Privacy Practices describing how my medical information may be used and disclosed and how I can access my medical information.

SIGNATURE:

RELATIONSHIP TO PATIENT: ______________________________
(If other than the patient)

DATE: ______________