Patients Name ____ D.O.B. _________________

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

Authorized for release of information by: **PARKVIEW PRIMARY CARE PHYSICIANS, PLLC**

I herby authorize the above named medical facility, having treated me, to release to govern-Mental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

______________________________________ _________________________ _____________
Signature of Patient or Authorized Representative Print Name & Relationship Date

Assignment to: **PARKVIEW PRIMARY CARE PHYSICIANS, PLLC**

I herby assign, transfer and set over to the above named medical facility, sufficient monies and/or benefits which I may be entitled from government agencies, insurance carriers, or others who are financially responsible for my hospitalization, and medical care to cover the costs of the care and treatment to myself or my dependent in said hospital.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

____________________ ____
Date Signature of Insured or Authorized Representative

____________________ ____
Date Signature of Physician

For **NO FAULT** Cases. **Please complete the following:**

Date of Accident: ______________________________

Automobile Owner ____

Address of Owner ____

Name of Insurance Co. ____

Claim Adjustor Name: ____________________________________ Phone #: ___________________

Address of Insurance Co. ____

City _________________________________ State _______________ Zip Code ______________

Policy / Claim # ____________________________ / ____________________________________

Did you complete a No Fault Application? ______ Yes _____ No