MULKAY CARDIOLOGY CONSULTANTS

HACKENSACK | UNION CITY | CLOSTER

CONSENT TO RELEASE INFORMATION

Name: _____ Date of birth: _____

I authorize and give consent for Mulkay Cardiology Consultants to release my medical records and any other necessary information to my insurance company in order to process my medical claim. In addition, I authorize the billing department of Mulkay Cardiology Consultants to appeal on my behalf any denied medical claims.

Signature: _____ Date: _____

CONSENTIMIENTO PARA DIVULGAR INFORMACION

Nombre: _____ Fecha de nacimiento: _____

Yo par la presente autorfzo y doy mi consentimiento a divulgar mis historiales medicos y otra informaci6n relacionada a mi compania de, seguros y autorizo a apelar en mi beneficio algun reclamo(s) negado.

Firma del paciente: _____ Fecha: _____