201 Cedar St. SE, Suite 304
Albuquerque, NM 87106

EMERGENCY INFORMATION

List the nearest friend or relative not living with you:

Name: _____ Relationship: _____

Home Address: _____
Number & Street City State Zip

Home Phone: _____ Work Phone: _____ Cell: _____

If we are unable to speak directly with you, please list spouse, family members or friends with whom we can speak regarding your personal health information.

Name: _____ Telephone # _____ Relationship: _____

Name: _____ Telephone # _____ Relationship: _____

Name: _____ Telephone # _____ Relationship: _____

CONSENT TO RELEASE INFORMATION

Southwest Gynecologic Oncology Associates, Inc. has my consent to release to any of my treating physicians any medical records pertaining to my continued medical care. I have also consented to the release of my medical records to any insurance companies through which I am insured (or to the employer if the coverage is through a group insurance plan) necessary to process claims for services provided.

ASSIGNMENT OF BENEFITS

In consideration of services rendered, I hereby irrevocably assign and transfer to Southwest Gynecologic Oncology Associates, Inc., insurance payment of medical benefits.

FINANCIAL RESPONSIBILITY

It is my understanding that I will be financially responsible for all services provided to me by Southwest Gynecologic Oncology Associates, Inc. in the course of my treatment.

CONSENT FOR TREATMENT

I hereby consent to medical treatment by the physicians and/or medical personnel of Southwest Gynecologic Oncology Associates, Inc. as directed by the physicians.

This signed document shall be considered valid for **up to two (2)** years from the date below. A photostatic copy of this shall be considered as effective and valid as the original.

_____ _____
Signature of Patient Date

PLEASE SEE OTHER SIDE