Capital Imaging, LLC

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Bethesda, Maryland 20814
Phone (301) 718-3411 Fax (301) 718-0805

Assignment and Authorization

You are hereby authorized to disclose and/or furnish my attorneys, ________________________________
Attorney's Name
any and all medical information, records and bills in your possession (including any and all medical information, records and bills from any other Health Care Provider) which they request in reference to any illnesses and injuries suffered by____ including but not
Patient's Name
limited to the injuries which were sustained on___________________________. The authorization to
Date of Incident
obtain medical records and information contained in this paragraph expires one year from the date unless extended or renewed in writing by me. I further, irrevocably assign to you, and authorize and direct said attorneys to pay from the proceeds of any recovery in my case all reasonable fees for services provided by you, including fees for preparation and testimony, as a results of the injury or condition heretofore mentioned. I understand this in no way relieves me of my personal primary obligation to pay for such services and that the signing of this form does not prohibit customary billing by you. All bills shall be paid promptly in the usual manner.

It is further understood that the statute of limitations in this State in three (3) years from the time said services were last performed and I further understand that because of long delays in trial dockets, many cases are not tried or settled until a date which is beyond the (3) years after the last service was performed. In view of this, I hereby agree that the statute of limitations with respect to any claim for services mentioned above will not begin to run until there is a denial in writing by us of any balance claimed to be due and owing to you by services by me.

Witness: ___________ Your Signature:____
Patient's signature

Date: ____________ Name:____
Print Patient Name

Patient's Home Address: ____
____

Relationship to Patient: Self Parent Guardian Other:____________

THE UNDERSIGNED ATTORNEY FOR THE PATIENT REFERRED TO ABOVE HEREBY AGREES TO COMPLY FULLY WITH THE FORGOING: "AUTHORIZATION AND ASSIGNMENT AND AGREES TO ADVISE THE NAMED HEALTH CARE PROVIDER IN WRITING THE STATUS OF THE CLAIM OF THE PATIENT WITH IN TEN(10) DAYS OF THE REQUEST. I AGREE TO NOTIFY THE PHYSICIAN IF I DISCONTINUE REPRESENTATION OF THE CLIENT.

Date: ____________ Attorney Signature: ____

Attorney Name: ____

Firm Name: ____

Firm Address: ____
____

Firm Phone/Fax: ____