EAST CENTRAL ONCOLOGY ASSOC., P.L.C.
Michel R.Hurtubise, M.D. - Daniel Y. Danso, M.D

RELEASE AND ASSIGNMENT

I authorize East Central Oncology Associates to release to my insurance company any information regarding my treatment, or diagnosis of my condition that they consider appropriate to obtain payment for services rendered to me. I also authorize and request such payment be made directly to East Central Oncology Associates, on my behalf for medical services.

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Signature of Patient/ Guarantor   Date

MEDICARE PATIENTS

I request payment of authorized Medicare benefits be made on my behalf to East Central Oncology Associates for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services.

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Signature of Beneficiary   Date

PLEASE BRING YOUR INSURANCE CARDS TO BE COPIED