

SOUTHERN WESTCHESTER ORTHOPEDIC & SPORTS MEDICINE ASSOCIATES, P.C.  
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NEW YORK NO FAULT MOTOR VEHICLE INSURANCE  
ASSIGNMENT OF INSURANCE BENEFITS

NAME OF PHYSICIAN PROVIDING HEALTH SERVICES: \_\_\_\_\_

PATIENT'S NAME AND ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_ FILE OR POLICY # \_\_\_\_\_

NAME OF INSURANCE COMPANY: \_\_\_\_\_

ADDRESS OF INSURANCE CO: \_\_\_\_\_

PHONE # & ADJUSTOR NAME: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_

**I authorize release of any medical information to my Primary Care Physician and/or insurance company. I also certify that I have read and have been given a copy of Southern Westchester Orthopedics & Sports Medicine Assoc., P.C.'s Notice of Privacy Practices describing how my medical information may be used and disclosed and how I can access my medical information.**

**SIGNATURE:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_  
**(If other than the patient)**

**DATE:** \_\_\_\_\_