Assignment of Benefits and Release of Information

I, ______________________________, request authorization for the Insurance company to
have payment made payable to the Guam Community Health Centers (Northern Region Community Health Center or Southern Region Community Health Center) in lieu of reimbursing me for services rendered on my behalf. I also authorize the release of my personal medical health information to any agents or third party payers which are needed to determine any benefits related to services provided to me by the Guam Community Health Centers.

Print Name of Patient or Authorized Representative:_________________________

Signature of Patient or Authorized Representative:_________________________

Date:_______________________