

Medical Billing Release Form

Full Name:	Phone Number:	
Address:		
City:	State:	Zip Code:
Authorization to Release Billing Infor	mation	
I hereby authorize the release of my billing inform		
below. This includes itemized billing statements, i billing records related to my care.	nvoices, payment	records, and insurance claim
billing records related to my care.		
Recipient Information		
Name of Individual / Organization:		
Phone / Fax / Email (if applicable):		
Address:		
City:	State:	Zip Code:
Durmoso of Disclosure		
Purpose of Disclosure □ Personal Records		
☐ Insurance Processing		
☐ Financial Assistance		
Other (please specify):		
_ care (piease speeny):		
Authorization Period		
This authorization is valid:		
 For a one-time release only 		
Until the following date:		
 Until revoked in writing 		
Acknowledgment and Signature		
I understand that this authorization only permits to not include clinical or treatment records. I may re		
understand that information disclosed may no lon		
once released.	,	, , , ,
Signature of Patient or Legal Guardian		 Date
Printed Name:		
Deletionalia to Detical (CN + C)		
Relationship to Patient if Not Self:		