Medical Billing Release Form

Patient Information

Full Name:_____

Date of Birth:_____ Phone Number:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Authorization to Release Billing Information

I hereby authorize the release of my billing information only to the individual or organization listed below. This includes itemized billing statements, invoices, 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:_____

Purpose of Disclosure

- ☐ Personal Records
- ☐ Insurance Processing
- ☐ Financial Assistance
- ☐ Other (please specify):_____

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 the release of billing-related information and does not include clinical or treatment records. I may revoke this authorization at any time in writing. I understand that information disclosed may no longer be protected by federal privacy regulations once released.

_____ _____

Signature of Patient or Legal Guardian Date

Printed Name:_____

Relationship to Patient if Not Self:_____