AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

I am authorizing the use and disclosure of protected health information for the following patient as described in this authorization and in accordance with HIPAA.

PATIENT NAME: ____

Date of Birth: ____________________ **Social Security Number:** ________________________

The following information may be released by Associated Billing Services, Inc. as a business associate of ____(Provider):

☐ **Billing records which include statements or itemized bills, insurance claim forms, explanation of benefits, records of billing to third party payers.**

☐ **Entire medical record including history, physical and consultation notes, treatments provided, diagnosis, prescriptions, questionnaires, treatment plans, test/lab results, correspondence, photos and any other items contained in my medical record.**

RELEASE TO:

____

Name

☐ **Healthcare Provider** ☐ **Facility** ☐ **Physician** ☐ **Other** ____________________________________

____

Street Address of the above named individual or entity ***City*** ***State*** ***Zip*** ***Phone***

FOR THE PURPOSE OF:

____

EFFECTIVE: _________________________ **TO: (date or event)**_____________________________

I understand that at any time I may revoke this authorization. To do so, a copy of the original authorization will be sent back to me and I will complete the REVOCATION OF AUTHORIZATION SECTION below. I also understand that the information disclosed may be re-disclosed by the individual or entity named above. I further understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned based on this Authorization. I acknowledge that I am voluntarily granting authorization to release the above designated information for the purposes described herein.

___________________________________ ___________________________________

Name of Patient or Personal Representative ***Signature of Patient or Personal Representative***

___________________________________ ___________________________________

(If Personal Representative, please indicate relationship to patient: spouse, parent, *legal guardian or *power of attorney. *Please include a copy of legal documentation.) ***Date***

Please keep a copy of this Authorization or Revocation thereof for your records.

REVOCATION OF AUTHORIZATION

On this day, _______________, I am revoking the above authorization for the release of the above information to the above named Healthcare Provider/Facility/Physician/Other Individual.

___________________________________ ___________________________________

Name of Patient or Personal Representative ***Signature of Patient or Personal Representative***

____

Date

Please keep a copy of this Authorization or Revocation thereof for your records.