Release of Information Authorization

Client Name: ____
Address: ____
____
City: ____________________ State: ___________ Province: __________________________
Country: ___________________________________ Postal Code: ________________________
Telephone: ___________________ Fax: ___________________ e-mail: _________________
Date of Birth: ___________________________Social Security Number: _____________________

I authorize XYZ Practice to release all medical records or other Protected Health Information (PHI), including intake forms, chart notes, reports, correspondence, billing statements, and other written information concerning my health and treatment as requested by my health insurance carrier, Medicare or any other third-party payers.

I authorize XYZ Practice to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to XYZ Practice.

I also authorize the release of my medical records or other PHI concerning my health and treatment during the period of __________ to __________ ; to be sent to the following person or company.:

Company: ____
Name: ____
Address: ____
____
City: ____________________ State: ___________ Province: __________________________
Country: ___________________________________ Postal Code: ________________________
Telephone: ___________________ Fax: ___________________ e-mail: _________________

I agree that these provisions will remain in effect until I provide written revocation to XYZ Practice.

____ ____________
Signature of Client or Authorized Representative Date