INSURANCE INFORMATION RELEASE/AUTHORIZATION FORM

Date: _____

To: _____

_____

_____

Attn: _____

_____ _____
Name Date of Birth

_____ _____
Account Number

_____ _____
Address City, State, Zip Code

I HEREBY GRANT AND AUTHORIZE [ADVOCATES NAME] OF [YOUR COMPANY NAME] ACCESS TO ANY MEDICAL RECORDS, REPORTS, CORRESPONDENCE, INSURANCE INFORMATION, AND BILLING INFORMATION AS REQUESTED

FROM _____ THROUGH_____

I authorize [YOUR COMPANY NAME] to correspond through any medium with you regarding the above. Should you have any questions, please call [YOUR COMPANY NAME].

Please address mailed correspondence to:
[ADVOCATE]
[COMPANY NAME]
[COMPANY ADDRESS]

Other authorized contact information:
Phone: [PHONE]
Secure Fax: [FAX NUMBER]
[EMAIL ADDRESS]

Please accept a Photostat copy of this authorization with the same authority as the original.

_____ _____
Signature Date of Signature

By my signature above, I acknowledge the release of any Protected Health Information (PHI) to [YOUR COMPANY NAME] as designated on this release form. This protected health information is to be disclosed under this authorization at my request, as permitted by 164.508©(1)(iv) of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act (“HIPAA Privacy Rule”). I acknowledge that I have received a copy of this authorization. This authorization will remain in effect until revoked. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for the revocation to [YOUR COMPANY NAME] and your company.