PRESTIGE MEDICAL BILLING CO. INC.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL BILLING INFORMATION

This form when completed and signed authorizes the release of your protected health information

Client Name:_____ Date of Birth:_____

I authorize Prestige Medical Billing Co., Inc. to ( ) release ( ) request ( ) exchange my protected health information from or to the following:

Name:_____

Address:_____

Phone:_____ **Fax:**_____

Email:_____

The following information is to be disclosed **(please initial blanks)**

_____All insurance and client billing information, including dates of service, type of services provided, account balances, payments on account either by insurance, third party, or the patient. The only Protected Health Information (PHI) that will be provided will be demographic and insurance information for purposes of obtaining payment on the account. Prestige Medical Billing Company will not disclosure treatment notes, diagnosis codes or description of diagnosis codes unless that code impacts the claim from being processed (pre-existing condition requirements).

Purpose: I am requesting the release of this information for the following reasons and subject to the following limitations:

_____

_____

This authorization expires in 90 days or until the following occurs _____.
(Not to exceed 90 days)

I understand that I have the right to revoke this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

1. Write, sign and date a letter canceling your authorization.
2. Sign, date and write **CANCEL** on this original form
3. Sign and date a revocation form. This form is available from your Therapist.

Once this information is released, it is beyond our control. The recipient might re-disclose it, as HIPAA privacy laws may no longer protect it. I understand that my therapist may not condition psychological services upon my signing an authorization.

_____

Client Signature Date

_____

Parent/Guardian Signature (If Patient is under 13 years of Age) Date

_____

Therapist/Witness Signature Date