

MedAmerica

BILLING SERVICES, INC.

1601 Cummins Drive, Suite D

Modesto, CA 95358

209-567-5755

Authorization for Release of Medical Billing Information

Please be advised beginning April 14, 2003, all requests/authorizations for patient medical and/or billing records must meet federal guidelines specified under the Health Insurance Portability and Accountability Act's (HIPAA) Privacy Rule (45CFR§164.508).

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

Patient Name _____

Date of Birth _____ Social Security No. _____

Approximate Date(s) of Treatment _____

Name of Hospital or Facility where treatment was rendered _____

Person/Entity Authorized to Release Information:

MedAmerica Billing Services, Inc.

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Modesto, CA 95358

Person/Entity Authorized to Receive Information:

1. Information to be released: Billing Records/Account Information*
2. Purpose of the disclosure: At the request of the individual
3. This authorization shall expire one year from the date signed.
4. I understand that I may revoke this authorization at any time by notifying MBSI in writing. However, the revocation will not be valid if:
 - (a) MBSI has taken action in reliance on this authorization; or
 - (b) if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
5. I understand that the information released by this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations.
6. I understand that I may obtain a copy of this authorization upon request.

Signature of patient

Date

Printed name of patient

Alternatively, in the case of an incompetent or incapacitated adult, deceased patient, or minor patient:

If you are not the patient, but a personal representative of the patient [as defined under California Civil Code § 56.11 (c)(2)(3)(4)], please sign and print your name and attach proof of the same to this authorization.

Signature of patient's representative

Date

Printed name of patient's representative

Relationship to patient or authority to act for the patient

* Please note: The release of information regarding mental health, drug and/or alcohol abuse and HIV/AIDS test results requires a specific authorization and no such information shall be released pursuant to this authorization.