Medical Information Release Authorization

I ________________________(patient name) hereby authorize any medical practioner, hospital, facility, insurance company or any other agency that has medical records or knowledge of my medical records to release such information to Chapman Consulting for the purpose of Chapman Consulting negotiating my medical bills on my behalf.

I hereby grant permission to Chapman Consulting to discuss any and all medical bill related information with any medical practitioner or hospital facility for the purpose of Chapman Consulting negotiating my medical bills.

Chapman Consulting will maintain the privacy of all information obtained and will not disclose such information to any other person or entity.

The authorization is valid for 90 days following the date of my signature shown below. I have the right to revoke this authorization in writing at anytime before the expiration of the 90 day period.

____
Print Patient Name

____
Signature of Patient/Legal Guardian
If Patient is a Minor

____
Address

____
City, State Zip

____
Date

____
Date of Birth

____
Patient Social Security Number

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