

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, LLC for the purpose of Chapman Consulting, LLC negotiating my medical bills on my behalf.

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

Chapman Consulting, LLC 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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