Chronic Illness Treatment Medical Authorization Release Form

(for Ongoing Insurance Claims)

Patient Full Name

Date of Birth

Address

Phone Number

Insurance Policy Number

Treating Physician / Practice

Physician Address

Physician Phone Number

Description of Chronic Illness or Condition

Treatment(s) Authorized/Received

Medical Records and Information Authorized for Release

To Be Released To (Name of Insurance Company/Adjuster)

Recipient Address

Purpose of Release

Authorization Period

From

To

Additional Instructions/Limitations (if any)

Patient Signature

Date