Third-Party Medical Information Release Authorization Form

(for Out-of-Network Insurance Claims)

Patient Information

Full Name

Date of Birth

Phone Number

Email Address

Address

Insurance Information

Insurance Company Name

Policy/Member Number

Group Number

Provider Information

Provider Name or Practice

Provider Address

Provider Phone

Authorization

I hereby authorize the above-named medical provider to release my medical information to the third-party insurance company identified above for the purpose of processing my out-of-network insurance claims.

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Release all pertinent medical records related to my claim(s)

If limited, specify information authorized for release:

Expiration

Authorization Expiration Date

Other Expiration Condition

Signature

Patient/Guardian Signature

Date

If signed by guardian, print name and relationship to patient: