HIPAA Authorization for Third-Party Billing

Patient Name

Date of Birth

Recipient of Information

Name of Third-Party (e.g., Billing Company)

Address

Information to Be Disclosed

Describe the health information to be disclosed

Purpose of Disclosure

Purpose of Disclosure (e.g., Billing, Payment, Claims)

Authorization Expiration

This authorization will expire on (date or event):

Your Rights

- You may refuse to sign this authorization.
- You may revoke this authorization in writing at any time.
- Your health care and payment for health care will not be affected if you do not sign this form.

Signature

Signature of Patient or Representative

Date

If signed by Representative, Relationship to Patient