MedAmerica
BILLING SERVICES, INC.
1601 Cummins Drive, Suite D
Modesto, CA 95358
209-567-5755

## Authorization for Release of Medical Billing Information

**Please be advised beginning April 14, 2003, all requests/authorizations for patient medical and/or billing records must meet federal guidelines specified under the Health Insurance Portability and Accountability Act's (HIPAA) Privacy Rule (45CFR§164.508).**

**I hereby authorize the use or disclosure of my individually identifiable health information as described below.**

**Patient Name** _____

**Date of Birth** _____ **Social Security No.** _____

**Approximate Date(s) of Treatment** _____

**Name of Hospital or Facility where treatment was rendered** _____

_____

**Person/Entity Authorized to Release Information:**

MedAmerica Billing Services, Inc.
1601 Cummins Drive, Suite D
Modesto, CA 95358

**Person/Entity Authorized to Receive Information:**

_____

_____

_____

1. Information to be released: Billing Records/Account Information*

2. Purpose of the disclosure: At the request of the individual

3. This authorization shall expire one year from the date signed.

4. I understand that I may revoke this authorization at any time by notifying MBSI in writing. However, the revocation will not be valid if:

(a) MBSI has taken action in reliance on this authorization; or

(b) if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

5. I understand that the information released by this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations.

6. I understand that I may obtain a copy of this authorization upon request.

_____ _____

Signature of patient Date

_____

Printed name of patient

Alternatively, in the case of an incompetent or incapacitated adult, deceased patient, or minor patient:

If you are not the patient, but a personal representative of the patient [as defined under California Civil Code § 56.11 (c)(2)(3)(4)], please sign and print your name and attach proof of the same to this authorization.

_____ _____

Signature of patient's representative Date

_____ _____

Printed name of patient's representative Relationship to patient or authority to act for the patient

* Please note: The release of information regarding mental health, drug and/or alcohol abuse and HIV/AIDS test results requires a specific authorization and no such information shall be released pursuant to this authorization.



Authorized Agent:
Knox Attorney Service, Inc./ Knox Services LLC.