Itemized Billing Statement Release

Date: _____

Patient Name: _____Last 4 digits of SS#_____

Patient Address: _____

Patient Date of Birth: _____ Patient Account # _____

I, _____

Hereby authorize _____

To release to: Advanced Medical Management

The following medical information from my personal medical records for services rendered

Between _____ and _____

X Itemized Statement(s) for Services Rendered

I give permission for this medical information to be used for the following reason:

__Payment of bill from third-party settlement or First-Party PIP Benefits_____

Please list any restrictions to the use of the medical record: ___ None_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present the written revocation to the manager of the treatment facility. I understand that revocation does not apply to information that has already been released. I understand that the information received may be subject to re-disclosure and may no longer be protected by federal or state privacy laws. I understand that treatment will not be denied solely for not signing this release..

Patient Signature: _____Date:_____

Witness Signature: _____Date:_____

This authorization is good for one year from the date above, unless otherwise revoked.