Patient Bill Defender

We Protect Patients from Unfair Medical Bills

Authorization to Obtain/Release Protected Health Information:

First Name:_____ Middle:_____ Last:_____ Suffix:_____

Date of Birth:(MM/DD/CCYY)_____ Medical Record Number: _____

Address Line 1: _____ Line 2: _____

City: _____ State:_____Zip:_____

Phone Number (Home): _____ Phone Number (Cell): _____

I, _____ request _____ located at [full address]:

_____to release my medical records to:

_____

Method of Disclosure authorized:

- ☐ **Mail (paper)**
- ☐ **Electronic Mail (send to _____)**
- ☐ **CD (Compact Disc) Mailed**
- ☐ **Electronic Download (send to _____)**

Records Requested:

Date Range of Medical Records: _____ to_____

☐ **Entire Medical Record, Itemized Bills, Billing Records, and copies of submitted claim forms.**	☐ **Discharge Summary**	☐ **Operative Reports**
☐ **History and Physical**	☐ **Radiology Reports**	☐ **Pathology Reports**
☐ **Laboratory Reports**	☐ **Emergency Dept Records**	☐ **Consultations**
☐ **Billing Records**	☐ **Radiology Films**	☐ **Progress Notes**

Note: Suppress After Visit Summaries, if able

Purpose of Disclosure: At the request of the patient or their legal representative, Billing Compliance., and/or claim submission

Signature:_____ Date: _____

☐ **The above named person signing the request authorized to obtain this medical information is the :**

☐ **Patient**	☐ **Parent (if patient is under 18)**	☐ **Executor of Estate** *Legal Documentation Required
☐ **Power of Attorney** *Legal Documentation Required	☐ **Guardian Ad Litem** *Legal Documentation Required	☐ **Unable to sign due to incapacity but is actively involved in care. (Facility: Please utilize procedures from 45 CFR 164.510 and request supervisor approval)**