



ITEMIZED STATEMENT/INFORMATION
RELEASE/AUTHORIZATION FORM

DATE: _____

TO: _____

ATTN.: _____

I HEREBY REQUEST AND AUTHORIZE YOU TO FURNISH FORMSCOPE, LTD. WITH A COPY OF MY DETAILED STATEMENT SHOWING PAYMENTS, CHARGES, AND ANY OTHER INFORMATION CONCERNING MY ACCOUNTS FROM: _____ 20____ TO _____ 20_____.

I AM WILLING THAT A PHOTOSTAT OF THIS AUTHORIZATION BE ACCEPTED WITH THE SAME AUTHORITY AS THE ORIGINAL.

PATIENT NAME

DATE OF BIRTH

PATIENT ACCOUNT NUMBER

CITY

ADDRESS

STATE/ZIP

SIGNED

DATE OF SIGNATURE

By my signature above, I acknowledge the release of any Protected Health Information (PHI) to the individual(s) designated on this release form. This protected health information is to be disclose under this authorization at my request, as permitted by 164.508©(1)(iv) of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule"). I acknowledge that I have received a copy of this authorization. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for the revocation to the Company.

This release will remain in effect and valid for 90 days from date of signature
This includes any future requests for any and all accounts regarding the above patients