NATIONAL BILLING ASSOCIATES, LLC

P.O. Box 2050, Lutz, FL 33548
Phone (813) 931-0000 Fax (813) 909-8517

HIPPAA COMPLIANT AUTHORIZATION TO RELEASE INFORMATION

FOR ______________________________ VALID THROUGH 12/31/2020

AUTHORIZATION: I authorize and direct any physician, medical practitioner, hospital, clinic, care provider, other medical or medically related facility; residential, residential care, or residential treatment facility, social service organization, insurance support organization, insurance company, reinsurance company, benefit plan administrator, pharmacy, attorney, employer, or other entity having information about me to release to National Billing Associates, LLC., or its agents or representatives, any and all information that possess concerning my medical care, treatment or advice including medical or other care records, diagnosis, pharmacy information including information about drug or alcohol abuse, mental and/or nervous conditions, and other non-medical information as deemed necessary by National Billing Associates, LLC..

REVOCATION: I understand that I have the right to revoke this authorization. Such revocation must be sent in writing to National Billing and will become effective when received by National Billing. I understand that if I refuse to sign this authorization, or if I revoke this authorization, National Billing may not be able to provide quality service.

DISCLOSURE AND REDISCLOSURE: National Billing will only disclose or re-disclose information in accordance with its notice of information practices.

PERIOD OF VALIDITY: This authorization shall be valid from the date signed and as long as my contract remains in force, unless revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original.

COPY RECEIVED: I acknowledge that I have received a copy of this authorization.

Signed ____ Dated _________________________

Name (please print) ____

If a personal or legal representative of the applicant/insured signs this authorization, complete the following:

Personal/Legal Representative's Name ____

Relationship to Applicant/Insured ____

Address of Personal/Legal Representative ____

Basis for Representation (POA, Guardian, etc.) ______________________________________
(PLEASE ATTACH COPY OF LEGAL DOCUMENT)