LMC
Liberty Medical Center
Improving Your Health
Improving Your Life
www.lchnh.org
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AUTHORIZATION TO RELEASE FINANCIAL INFORMATION

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is designed to protect the privacy of a patient's medical records. Confidential records include medical visit notes, diagnoses, health insurance information and billing/payment information, and which cannot be processed/released without written consent from the patient. By signing this form, the patient authorizes Liberty Medical Center personnel to release confidential financial information to the designated person(s).

Patient Name: _____

Guarantor Number: _____

I authorize the Medical Records or Business Office with Liberty Medical Center to discuss confidential financial account information for the purposes of understanding and meeting related financial obligations with the person(s) listed on this form.

I understand that the person(s) listed on this form will have access via telephone, in person, or by U.S. and electronic mail to information that would only include the following:

_____ My medical insurance associated with my account, including eligibility status and processing.

_____ My billing statement, including credits and debits posted to that account, and account balance, including amounts owed.

This authorization form does not allow Liberty Medical Center to release specific medical information.

Name(s) of people authorized to receive financial information to: (Please print)

_____

_____

This authorization will remain in effect until revoked in writing by the patient or the patient is no longer covered by another person's health insurance, or the patient reaches twenty-six (26) years of age.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____