

**Authorization for Release or  
Use of Billing/Financial Information**

Patient Name \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

I authorize Midlakes Management to discuss **billing/financial** information with:

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Name of Person

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Address

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City, State, Zip Code

Purpose for this request: (Check one of the following)

\_\_\_\_\_ Patient Request                      \_\_\_\_\_ Other – Specify \_\_\_\_\_

Type of Information Requested: (Check one of the following and date of service MUST be included)

\_\_\_\_\_ Billing/Financial/Information for the **ALL** dates of service:

Information that I wish NOT to have disclosed includes:

All other Protected Health Information (Including but not limited to appointment information, clinical lab work, diagnosis, test results, treatment, etc...)

I understand that:

- ?? The requested information may contain information which could identify diagnosis and methods of treatment.
- ?? The privacy regulations do not apply to family members and therefore the information stated above could be redisclosed.
- ?? I have read the above and authorize the disclosure of the billing/financial information as stated. I also acknowledge that I may receive a copy of this form if I request it.
- ?? I may revoke this authorization at any time by submitting a written request to Midlakes Management, except where disclosure has already been made in reliance on my prior authorization.
- ?? I may refuse to sign this authorization - it is strictly voluntary.
- ?? This authorization shall remain in full force and effect: (Check one of the following)

\_\_\_\_\_ Indefinitely

Signature of Patient or Representative \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient (if requestor is not the patient) \_\_\_\_\_ Date \_\_\_\_\_

**Please complete and return to Midlakes Management 67 Kendall Street Clifton Springs, NY 14432**