TEAMWORK HEALTH
BETTER TOGETHER

Consent for Release of Billing Information

Instructions: Please complete all sections of this release of billing information form. If any sections are left blank, this form will be invalid, and it will not be possible for TeamWork Health PLLC to obtain payment from your insurance company for services rendered.

Patient Full Name: _____

Patient Date of Birth: _____

AUTHORIZATION TO RELEASE BILLING INFORMATION

I authorize TeamWork Health PLLC to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any account, medical, and treatment information needed for payment purposes for services rendered.

I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents.

I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies including, but not limited to payment, billing, and coordination of benefits inquiries.

I understand:

- This authorization allows the release of information related to my billing, payments, and insurance claims.
- This does not authorize the release of my medical records or protected health information unless specified separately.
- This authorization will remain in effect until revoked by me in writing.
- That I have the right to revoke this authorization at any time by calling ***(919) 883-1583*** except to the extent that action has already been taken based on this authorization.

Patient Signature: _____

Date: _____

*Please call **(919) 883-1583** if you have questions regarding this policy document. For questions regarding your bill, please e-mail **billing@twhasg.com**.*