Northern Illinois Vein Clinic

Patient Name ______________________________

Birth date ______________________ **MRN** ______________________

Release of Medical Information for Payment of Claims

I consent and request Northern Illinois Vein Clinic, Rockford, IL, furnish my insurance company or other third party payor the following specific information contained in my medical records for review, examination and/or photocopies: an insurance claim form and documentation related to billed services which may include chart notes, ancillary test results and procedures.

The purpose of this disclosure is for my insurance Company or other third party payor to process payment for my medical services. I understand that the information provided pursuant to this release of information may contain mental health, developmental disabilities, alcohol/drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS)/HIV information. I understand that I may inspect and/or arrange for photocopies of the information that is to be disclosed. I understand that this authorization allows the aforementioned information to be released orally or through copies of medical records.

I understand that if I refuse to sign this release of information, the information will not be furnished (except as required by law), and my insurance company or other third party payor cannot be billed. In such case, I will be financially responsible for all charges incurred.

This release will remain in effect for one (1) year from date of signature below. I understand that this release may be revoked by me at any time. Any revocation must be in writing, signed by me and my signature must be witnessed by a person who can attest to my identity. No written revocation of consent shall be effective to prevent disclosure of records and communications until it is received by Northern Illinois Vein Clinic, and no revocation will be effective to the extent Northern Illinois Vein Clinic has already taken action in reliance on it.

Assignment of Benefits

I assign payment of medical benefits to Northern Illinois Vein Clinic for services described. I understand that **I am financially responsible for charges not covered plus any and all costs incurred in or related to the collection** of such charges including but not limited to, reasonable collection agency charges, not to exceed 50% of the principal, attorneys' fees, and costs of suit.

Privacy Notice

- ☐ I have received Northern Illinois Vein Clinic's Notice of Privacy Practices.
- ☐ I have been offered Northern Illinois Vein Clinic's Notice of Privacy Practices and decline to accept.

***(Print)* Patient** (Required on all age 12 and over)	**Date**	***(Sign)* Patient**	**Date**
***(Print)* Parent/Legal Guardian** (Required on all under age 18)	**Date**	***(Sign)* Parent/Legal Guardian**	**Date**
***(Print)* Witness**	**Date**	***(Sign)* Witness**	**Date**