

Authorization For Release Of Medical Records & Hippa Acknowledgment

STILL ME INC FITTING DESIGNS INC STILL ME MEDICAL

Please return via fax 225-273-5555

PATIENT INFORMATION (please print)			
NAME		DATE	
ADDRESS			
CITY	STATE	ZIP CODE	
HOME PHONE	ALT PHONE		
EMAIL ADDRESS			

AUTHORIZATION FOR RELEASE OF INFORMATION

I consent to the authorization to allow STILL ME INC, FITTING DESIGNS INC, STILL ME MEDICAL to (1) release any medical or other information necessary to insurance carriers regarding my illness and treatments; (2) obtain necessary medical records from current and previous treating physicians to determine medical necessity for eligible services; (3) verify and obtain medical benefits, as well as, submit insurance claims generated in the course of services received from this provider. I also authorize STILL ME INC, FITTING DESIGNS INC, STILL ME MEDICAL to appeal any unfavorable decisions determined by my insurance carrier which may result in claim denials or nonpayment on my behalf.

I acknowledge that I have been offered the Notice of Privacy Practices.

PATIENT SIGNATURE:	Date	

PLEASE RELEASE A COPY OF MY MEDICAL RECORDS, INCLUDING BUT NOT LIMITED TO PROGRESS NOTES AND CLINICAL NOTES FROM:

FACILITY/PHYSICIAN NAME: _____

PHONE:		FAX:	
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