PATIENT CONSENT FOR RELEASE OF BILLING INFORMATION

Account Number(s): _____ MRN: _____

Patient Name:_____

Address: _____

City, State: _____

Zip Code: _____

_____

To be completed by Patient

I, _____, hereby give Athena Medical permission to
Print Patient's Name

release my billing information to

_____, my _____
Print Name of Person Relationship to Patient

_____ _____
Patient's Social Security Number Patient's Date of Birth

_____ _____
Signature of Patient Date Signed

_____ _____
Signature of Witness Date Signed

NOTE TO PATIENT: For confidentiality reasons we will ask your designated representative for the last four digits of your Social Security Number and for your date of birth.