# **AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION**

**PATIENT:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| |  | | --- | |  | | **Name of Individual/Previous Names** | | | |  | | --- | |  | | **Birth Date** | | |
| |  | | --- | |  | | **Street Address** | | |  | | --- | |  | | **City, State, Zip** | | | |  | | --- | |  | | **Phone** | |

**AUTHORIZES: DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| |  | | --- | | Alliance Collection Agencies, Inc | | **Individual(s)/agency/organization making disclosure** | | |  | | --- | |  | | **Individual/agency/organization receiving information** | |
| |  | | --- | | PO BOX 1267 | | **Street Address** | | |  | | --- | |  | | **Street Address** | |
| |  | | --- | | Marshfield, WI 54449 | | **City, State, Zip Code** | | |  | | --- | |  | | **City, State, Zip Code** | |

**INFORMATION TO BE USED AND/OR DISCLOSED:**Itemized statement of patient account and/or information related to services placed to collections.

**PURPOSE FOR NEED OF DISCLOSURE:**Billing, collection or payment of claims.

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:  
Right to Receive Copy of This Authorization** – I understand that if I sign this authorization, I will be provided with a copy of this authorization. **Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form. **Right to Withdraw This Authorization** – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Alliance Collection Agencies, Inc. I am aware that my withdrawal will not be effective until received by Alliance Collection Agencies, Inc. and will not be effective regarding the uses and/or disclosures of my health information that Alliance Collection Agencies, Inc. has made prior to receipt of my withdrawal statement. **Right to Inspect or Copy the Health Information to Be Used or Disclosed** – I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Alliance Collection Agencies, Inc.

**REDISCLOSURE NOTICE** I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

**EXPIRATION DATE:** This authorization is good until I cancel this authorization in writing.

**SIGNATURE PATIENT/LEGAL REP: DATE:**  .   
 *(If signed by other than patient, state relationship with signature)*