

Medical Information Release Authorization

I _____ (patient name) hereby authorize any medical practitioner, hospital, facility, insurance company or any other agency that has medical records or knowledge of my medical records to release such information to Pickett Consulting for the purpose of Pickett Consulting negotiating my medical bills on my behalf.

I hereby grant permission to Pickett Consulting to discuss any and all medical bill related information with any medical practitioner or hospital facility for the purpose of Pickett Consulting negotiating my medical bills.

Pickett Consulting will maintain the privacy of all information obtained and will not disclose such information to any other person or entity.

The authorization is valid for 365 days following the date of my signature shown below. I have the right to revoke this authorization in writing at anytime before the expiration of the 365 day period.

Print Patient Name

Signature of Patient/Legal Guardian

Address

Date of Birth

City, State Zip

Patient Social Security Number

Date

Phone Number

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