insurancepal
Your benefits at your finger tips

Phone: (888) 918-0830 | Fax: (888) 316-8572 | Support@insurancepal.net | www.insurancepal.net

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth:

Authorized Name: Date of Birth:

Relationship to Patient:

Employers Company Name: Group #:

I request and authorize records to be released to the following individual(s):

INSURANCE PAL
PO BOX 885
Bountiful, UT 84010
(888) 918-0830

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates

(●) All healthcare information ( ) Other:

Additional Information(CPT Codes, DX Codes, Other):

Estimated Treatment Dates. (If Unknown) type "TBD")

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I authorize CBG Health or insurance company to release any information required to process my claims or to negotiate healthcare pricing and benefits.

☑ Yes ☐ No I authorize the release of my Medical records, insurance information and other information pertinent to getting my healthcare services and healthcare claims paid.

☑ Yes ☐ No I authorize the release of any records regarding dental, drug, alcohol, or mental health treatment or other information pertinent to getting my claims paid to the person(s) listed above.

Signature: Date signed: