SLB Medical Group, LLC d.b.a SLB Billing

Medical Information Release Form

(HIPAA Release Form)

Please Print

Patient Name: _____ Date of Birth: _____/____/_____

Provider Name:_____ Est. Due Date:____/ ____/ _____

Release of Information

[ ] I authorize the release of information including my personal demographics, insurance details, diagnosis, and medical records for SLB Medical Group, LLC to use as required for insurance purposes.

[ ] I understand that SLB Medical Group, LLC will contact my insurance company on my behalf to assist me in getting my claims processed and paid for the services rendered by my provider.

Patient Signature: _____ Date: ____/____/_____

This Release of Information will remain in effect until your file is closed

Office use only

SLB Staff:_____ Date Rcv'd: ___/____/_____