4700 Grapevine Way
Davie, Florida 33331
Office: (954)880-0217 Fax: (954)880-0218

ITEMIZED STATEMENT/INFORMATION RELEASE/AUTHORIZATION FORM

DATE: ______________________________________

TO: ______________________________________

____

ATTN.: ______________________________________

I HEREBY REQUEST AND AUTHORIZE YOU TO FURNISH ASSENT MEDICAL COST MANAGEMENT, INC. WITH A COPY OF MY DETAILED STATEMENT SHOWING PAYMENTS, CHARGES, AND ANY OTHER INFORMATION CONCERNING MY ACCOUNTS FROM: ______________________ 20______ TO ____________________ 20______.

I AM WILLING TO ALLOW A PHOTOSTAT OF THIS AUTHORIZATION TO BE ACCEPTED WITH THE SAME AUTHORITY AS THE ORIGINAL.

______________________________	______________________________
PATIENT NAME	DATE OF BIRTH
______________________________	______________________________
PATIENT ACCOUNT NUMBER	SOCIAL SECURITY NUMBER
______________________________	______________________________
ADDRESS	CITY/STATE/ZIP
______________________________	______________________________
SIGNED	DATE OF SIGNATURE

By my signature above, I acknowledge the release of any Protected Health Information (PHI) to the individual(s) designated on this release form. This protected health information is to be disclose under this authorization at my request, as permitted by 164.508©(1)(iv) of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule"). I acknowledge that I have received a copy of this authorization. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for the revocation to the Company.

- This release will remain in effect and valid for 90 days from date of signature
- This includes any future requests for any and all accounts regarding the above patients