



Authorization to Release Personal Health Information (PHI) to Insurance Carrier

I hereby authorize payment directly to All Sports Medicine of Boulder, PC and authorize the practice to release all information necessary to obtain payment for services provided. This authorization applies to all insurance companies and/or their intermediaries (either directly or through a third party billing company), including Medicare, private health insurer, HMO, or other company or program that is designated to pay for my health care. I understand that this information might be released for making a determination of eligibility or coverage for insurance benefits, reviewing services provided to determine medical necessity if required by my insurance company, and undertaking utilization review or case management activities with respect to claims.

I understand I am responsible for fees not paid in full, co-payments, and policy deductibles except where my liability is limited by contract or State or Federal law. I understand that filing a claim for payment with my insurance company, or other party, does not relieve me from the responsibility of payment for charges for services delivered to me or my dependents.

I agree that this authorization shall remain in effect until the authorization is revoked.

Signature of Patient or Guardian: _____

Date (mm/dd/yy): ___/___/___

Printed Name of Patient or Guardian: _____