



**RELEASE OF INFORMATION**

I AUTHORIZE any physician, medical practitioner, hospital, clinic, or other medically related facility, peer review organization, insurance or reinsuring company, the Healthcare Financing Administration, the Medical Information Bureau, Inc., consumer reporting agency, or third party administrator having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents to give to the group policyholder, my employer, third party administrator, my third party carrier, or its legal representative, any and all such information.

I UNDERSTAND the information obtained by this authorization will be used to determine eligibility for insurance and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim or claims submitted by Dr. Norris, Dr. Blessinger, Will Walker, NP, or Kelsey Vonderheide, PAC, or as may be otherwise lawfully required, or as I may further authorize. I AGREE that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I AUTHORIZE payment of medical benefits to be made to NORRIS & BLESSINGER ORTHOPAEDICS & SPINE, on any claim submitted for any services furnished me by either Dr. Norris, Dr. Blessinger, Will Walker, NP, or Kelsey Vonderheide, PA-C.

I have received a copy of the Privacy Practices of Norris & Blessinger Orthopaedics & Spine.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

**COST OF COLLECTIONS**

In the event any unpaid balance is assigned for collections with any third party and/or an attorney to obtain judgment or otherwise satisfy payment of this account, I am obligated to pay the costs incurred directly or indirectly by Dr. Norris, Dr. Blessinger, Will Walker, NP, or Kelsey Vonderheide, PA-C, to collect amounts owed such as 33 1/3% collection costs, court costs, attorney's fees, interest, late fees, sheriff's fees, and the like. In the event of a returned check, there will be a fee assessed of \$22.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_