HUDSON HEADWATERS
HEALTH NETWORK

☐ Patient or Legal Representative refused to sign/complete this document.

AUTHORIZATION TO RELEASE BILLING INFORMATION

I, _____, _____ authorize the release of any medical or other
(Patient's name) *(date of birth)*
information necessary to my health care insurer(s) in order to process any claims associated with services that I have received from Hudson Headwaters Health Network (HHHN). [1]

Furthermore, I authorize payment of medical benefits to HHHN from my health care insurer(s) for any claims associated with services that I have received from HHHN. [2]

I understand that my refusal to sign this form may prevent my health care insurer(s) from paying HHHN for my services. I understand that I will be personally responsible for any charges associated with any service(s) rendered if this occurs.

_____	_____	_____
Signature of Patient or Representative Authorized by Law	Print Name	Date

[1] This is a requirement of CMS 1500 form, box 12.
[2] This is a requirement of CMS 1500 form, box 13.