Pediatrics Partners, LLC – BILLING OFFICE
P.O. Box 812
Westminster, Maryland 21158
410-876-5660
410-751-7113 (FAX)

AUTHORIZATION TO DISCUSS MEDICAL BILLS
Patients 18 years of age and older

Patient's Name: _____ **Patient ID#:** _____

Once you reach 18 years of age, Maryland law gives you control over your medical information rather than your parents. The law does give us permission to speak to another health care providers or your insurance company regarding your medical care. If you wish to give us permission to speak to your parent(s), or others, regarding any outstanding balance you may have with our practice, please read and complete the areas indicated on this form. **If you do not wish to give permission, please complete the section at the bottom of this form. Please return this authorization to the above address or fax number.**

1. **Name** _____ **Relationship (ex: mother, father)** _____

2. **Name** _____ **Relationship (ex: mother, father)** _____

I understand that this allows Pediatric Partners, LLC Billing Office to disclose financial information regarding any visit. If I wish to change this authorization for a specific visit, I must notify Pediatric Partners, LLC Billing Office.

I understand that I can revoke this authorization at any time in writing to the above address. Revocation will not apply to information already disclosed with authorization.

Pediatric Partners, LLC will not deny or delay treatment or payment of claims if I refuse to sign this authorization.

YES, I WISH TO AUTHORIZE DISCLOSURE AS STATED ABOVE

Signature: _____ Date: _____

Phone Number: _____

NO, I DO NOT WISH TO AUTHORIZE DISCLOSURE TO ANYONE AT THIS TIME

Signature: _____ Date: _____