Estrella Pediatrics, P.C.
9305 W. Thomas Road Ste. 125 & 575
Phoenix, AZ 85037
(623) 388-3216 (623)388-4902
Medical Records Fax: (623) 225-7967

AUTHORIZATION TO RELEASE BILLING LEDGER

Patient Name: _____ **Date of Birth**: _____
Print First Name, Last Name

Patient Name: _____ **Date of Birth**: _____
Print First Name, Last Name

Patient Name: _____ **Date of Birth**: _____
Print First Name, Last Name

Patient Name: _____ **Date of Birth**: _____
Print First Name, Last Name

Address:
_____

_____ _____

Phone #: _____ Work #_____Cell #_____

I hereby authorize Estrella Pediatrics, P.C. to send/release the billing ledger concerning the above named patient(s) to:

Name of person(s) authorized to receive copy of billing ledger

Address: _____
City State Zip

Phone: _____ Fax:_____

This information is to be disclosed for the purpose of: _____

I authorized the release of the billing ledger. I understand that when my child's information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule.

Patient or Personal Representative's Signature Relationship to Patient Date

Signature verified: Yes ___ No ___ EPPC Rep. Int: _____