Release of Information

I HEREBY AUTHORIZE ALBERT T. DOMINGO MS MD INC, TO DISCLOSE ALL OR ANY PART OF MY MEDICAL INFORMATION TO:

1. Any person or entity that may be liable to Albert T. Domingo MS MD Inc, for all or part of the charges for my medical care, including but not limited to: Hospital or Medical Service Companies, Insurance Companies, Medical Claims Payers, Medicaid and Medicare.

2. Any person on entity that is involved in my medical treatment, and communication among many health professionals who contribute to my care.

3. My employer;

4. The legal Counsel of Albert T. Domingo MS MD Inc, in any matter to which such information is relevant and necessary;

5. Collection agencies retained by Albert T. Domingo MS MD Inc. to obtain payment of my account;

6. Persons or entities performing audits, or analyzing patient medical information for peer review, quality of care, financial or compliance purposes. (A means by which a third-party payer can verify that services billed were actually provided)

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Albert T. Domingo MS MD Inc to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made **direct** to Albert T. Domingo MS MD Inc, and I certify the information I reported in regards to my insurance coverage is correct. This authorization may be revoked by either me or my insurance company at any time in writing. I understand that **I am financially responsible** for any balances not covered by insurance.

Signature _____ Relationship to patient _____

Form completed by _____ on _____ Date of Birth: _____

Information reviewed: ____ /20 ____/21 ____/22 ____/23 This form needs **reviewed** yearly!