PATIENT CONSENT FOR RELEASE OF BILLING INFORMATION

Account Number(s): ______________________________ MRN: _________________

Patient Name: ____________________________________

Address: ____

City, State: ______________________________________

Zip Code: ____

To be completed by Patient

I, ____________________________________, hereby give Sansum Clinic permission to
Print Patient's Name

release my billing information to

______________________________________, my ________________________________
Print Name of Person Relationship to Patient

______________________________________ ________________________________
Patient's Social Security Number Patient's Date of Birth

______________________________________ ________________________________
Signature of Patient Date Signed

______________________________________ ________________________________
Signature of Witness Date Signed

NOTE TO PATIENT: For confidentiality reasons we will ask your designated representative for the last four digits of your Social Security Number and for your date of birth.

☐ Please return completed form to:
Sansum Clinic Patient Accounts
P.O. Box 62106
Santa Barbara, CA. 93160

☐ Please return completed form to:
Sansum Clinic Claims
P. O. Box 6426
Santa Barbara, CA 93160

Clinic Staff: Forward original to HIS after documenting in IDX