Bertrand Wicholas MD
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Authorization to Release Information for Treatment, Billing, or Health Care Operations

You are not required to give this authorization. However, claim charges denied due to a failure to provide requested documents (due to a lack of authorization) will be the responsibility of the patient.

I understand that I have the right to review the Privacy Notification prior to signing this consent. I understand that Bertrand Wicholas MD reserves the right to change his notices and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations, and the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Records may be needed in order to process a claim for medical services. I authorize Bertrand Wicholas MD to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories. I understand that by signing below, I am authorizing the release of all or part of my medical record for the purpose of my **treatment, billing, or pertinent health care operations.** This release may include records containing information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under contract for all or part of the medical charges, including but not limited to, Medicare, Medicaid, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer.

Patient Signature _____Date _____