Authorization for Release of Billing Records

Records held by Sunset Billing Archive (The Buckson Group, LLC, Records Custodian)

Patient name _____ Date of birth _____ Other names used _____

Practice whose records are requested _____ Address at time of treatment _____

Records to be released

I authorize Sunset Billing Archive to release the following **billing and account records**:

☐ Itemized ledger / statements ☐ Payment history ☐ Balance verification

☐ Appointment history ☐ Reconstructed CMS-1500 (if available)

☐ Other: _____

For dates of service from _____ to _____ Limited to payer / injury / case (optional) _____

Recipient

To (recipient name and organization) _____

Recipient mailing address _____ Recipient fax or secure email _____

Purpose and expiration

☐ At my request ☐ Legal matter ☐ Insurance ☐ Continuity of care

☐ Other: _____

This authorization expires on _____ (date) or upon _____ (event). If no date or event is given, it expires one year from the date signed.

My rights

I understand that: (1) I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it; (2) information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy law; (3) my treatment, payment, enrollment, or eligibility for benefits is not conditioned on signing this authorization; (4) I am entitled to a copy of this authorization.

Signature

Signature of patient or personal representative _____ Date _____

Printed name

If representative: relationship and authority (attach documentation)

Return to: Sunset Billing Archive, c/o The Buckson Group, LLC, 2624 Timber Dr, Suite 151, Garner, NC 27529 · **Fax:** 888-518-4948 · or upload through the secure link on the Request Records page at sunsetbillingarchive.com. A copy of the signer's government photo ID must accompany this authorization.