



**MBA Medical Billing Services, Inc**  
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## **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

**Date Of Authorization**

**Expiration Date**

**Patient Name**

**Responsible Party**

### **Parties authorized to access protected health information:**

### **Reason for disclosure (Not Required):**

**Signature of Authorized Party**

**Relation to Patient**

Our organization is dedicated to upholding a high standard of confidentiality. Our privacy policies meet or exceed the requirements set forth by the Health Insurance Portability and Accountability Act (HIPAA). The right to access protected health information is available only to the parties listed above and those directly involved in the care, or business related to the care, of the patient. However, we reserve the right to refuse access to any of those parties if there is reason to suspect they will not uphold a similar standard of confidentiality.