



PATIENT: \_\_\_\_\_  
EMPLOYEE: \_\_\_\_\_  
CLAIM NO: \_\_\_\_\_  
PROVIDER: \_\_\_\_\_

GROUP NO: \_\_\_\_\_  
ACCT NO: \_\_\_\_\_  
INCURRED: \_\_\_\_\_  
CHARGE: \_\_\_\_\_

RE: Authorization to Release Information

To Whom It May Concern:

We have received a claim for the patient named above. In order to complete the processing of this claim, we require additional records and documents from your health care providers. Please complete the bottom portion of this letter and return to our office.

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize any physician, surgeon, practitioner or other person, any hospital, including Veterans Administration or Government hospital, any medical service organization, any insurance company, or any other institution or organization to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other disabilities.

A photocopy of this authorization shall be as valid as the original.

\_\_\_\_\_  
(Signature of Patient or Guardian)

\_\_\_\_\_  
Date

The requested information must be received by HealthComp within forty-five (45) days from the date of the initial request or the claim will be denied/closed. If you have any questions, please contact our office at (800) 442-7247 or Fax (559) 499-2464.

Sincerely,

HealthComp Administrators  
Claims Department