



MEDICAL CLAIMS SERVICE

PO BOX 1265

REDMOND, OR 97756

Phone: (541) 504-4676 Fax: (541) 526-1092

AUTHORIZATION TO RELEASE INFORMATION

The following request is made under the Privacy Act of 2002:

I hereby authorize you to release to Becki McKinney, MEDICAL CLAIMS SERVICE and any of its representatives, any medical records, insurance information or Medicare information upon their request.

Time Frame: Ongoing Limited (give date range) _____

Please place this authorization on file so we can receive information on this account.

NAME _____

SSN _____

ADDRESS _____

SIGNATURE _____

DATE _____