KIRA STEIN, MD, APC
433 N Camden Drive, Suite 600
Beverly Hills, CA 90210
TEL 310-529-6051 ◆ FAX 888-959-0148

AUTHORIZATION TO RELEASE & EXCHANGE BILLING INFORMATION

I, (patient name)_____hereby authorize clinicians and staff at Kira Stein MD, APC to request and facilitate payment from, as well as release billing statements, superbills, receipts, and other billing and reimbursement-related issues associated with my account (which may include diagnostic codes and information) to (name) _____, who can be reached at:

- Telephone: _____
- Email: _____
- FAX:_____
- Full Street Address: _____.

1. The purpose of such disclosure is for use in connection with **billing/payment/reimbursement of my care**

2. I understand that there is a risk that the person or entity receiving information or documents from Kira Stein MD, APC pursuant to this authorization may re-disclose the information and documents in a manner, which will no longer provide protection for the information and documents.
3. I understand that I may refuse to sign or may choose to revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment with Kira Stein MD, APC.
4. If I choose to revoke this Authorization in the future, the revocation will be effective immediately upon Kira Stein MD, APC's receipt of my written notice, except that the revocation will not have any effect on any action taken by Kira Stein MD, APC in reliance on this Authorization before Kira Stein MD, APC received my written notice of revocation.
5. I understand that I may receive a copy of this authorization.
6. I understand that this release automatically expires one (1) year from today's date**, unless** I authorize the following expiration by checking the associated box:

   ❑ I would like this authorization to expire only 180 days after my care with Kira Stein MD, APC has terminated.

   ❑ I would like this authorization to expire on the following date: _____

A scan, photocopy or facsimile of this signature is as valid as the original.

_____
Patient Name (printed)

_____ _____
Patient Signature Date signed