# Medical Records Release Form

I do hereby consent and authorize Express Collections, Inc. to obtain copies of my medical records as described below:

Name _____ SSN _____

Address _____

City _____ State_____ Zip _____

Date of Birth _____ Phone _____

## Records Requested:

Name of Clinic, Doctor, or Facility _____

Dates of Service (or Date Range) _____

**Please select all specific documents that apply to your request:**

☐ Itemization of services/procedures rendered ☐ Insurance EOB's ☐ Billing Statements

☐ Other_____

I understand that this authorization is voluntary. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature Date

_____ _____

Printed Name Relationship, if not patient
(i.e. parent, guardian, POA, Executor)

Please complete this form and fax to: 605-342-7195 (or)
e-mail it to: legaldept@expresscollections.com (or)
Mail it to: Express Collections, PO Box 9307, Rapid City, SD 57709

This is an attempt to collect a debt; any information obtained will be used for that purpose. This communication is from a debt collection agency.