Health Network Solutions, Inc. (HNS)
Billing Company
Physician Authorization and Release

This form shall serve as confirmation that I use the services of the individual or entity named below for purposes of procuring payment for services I provide to members whose healthcare plans contract with HNS, and for purposes of assisting with the management of my accounts receivable. Further, this form shall serve as my authorization for HNS to release information to the below named individual, or representatives of the entity named below, relative to their efforts to manage my accounts receivable for services I provide to members whose healthcare plans contract with HNS.

I specifically acknowledge that this authorization for HNS to release information to this individual or entity may include the release of protected health information (PHI).

I understand that it is my responsibility to notify HNS if my relationship with this individual or entity terminates. I understand that this authorization shall remain in effect unless and until I notify HNS, *in writing,* that my relationship with this individual or entity has terminated.

_____

Name of Individual or Entity

_____

Address

_____

City, State and Zip

_____

Contact Name

_____

Phone Fax

Business Associate Agreement (BAA). As a reminder, as a covered entity under HIPAA, physicians who utilize a billing company are required to have a Business Associate Agreement with the billing company. In order for HNS to communicate/share PHI with representatives of the billing company, HNS must first receive an executed copy of the BAA.

_____ _____

Physician's Name (please print) Date

_____

Physician's signature