AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I understand and consent that McFee Medical/OWL Leasing has the right to exchange and/or release any and all portions of my medical record to my insurance company, whether commercial or Medicare. McFee Medical/OWL Leasing may also contact my physician's office for any pertinent medical records and/or personal health information (PHI) including but not limited to: requesting a letter of medical necessity and any relevant medical records for insurance purposes.

I understand that McFee Medical/OWL Leasing is an out of network, non-participating provider and will bill my credit card for the rental charges. Upon my request, McFee Medical/OWL Leasing will submit an insurance claim to my private insurance company for possible reimbursement. I understand McFee Medical/OWL Leasing does not guarantee payment from insurance companies for the rental charges, even with an authorization from my insurance company. I also acknowledge that McFee Medical/OWL Leasing does not accept government assignment and that I am fully responsible for all rental charges.

All of the above has been explained to me and all questions regarding this release have been answered to my complete satisfaction.

_____ _____

(Signature of Patient or Guardian) (Date)

THIS AUTHORIZATION EXPIRES ONE YEAR FROM THE DATE IT IS SIGNED