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RELEASE OF RECORDS AUTHORIZATION
| DOB:

RELEASE OF RECORDS AUTHORIZATION

I hereby authorize the release of medical information to any of my health care providers or insurance companies that may be pertinent to my case. I hereby authorize direct payment of insurance benefits that are otherwise payable to me. I hereby authorize the release of my medical records to the third-party insurers or other persons whom disclosure is necessary to establish or collect a fee for services provided. I understand that I am financially responsible for all charges arising from from the treatment of myself (or the above-named patient, if applicable). I understand that payment in full is due at the time services are rendered; however, I agree to pay a FINANCIAL CHARGE of 1.5% per month for balances over ninety (90) days past due [3% per annum]. If my account is referred to an attorney for collection, I agree to pay all collection and court costs, including attorney fees equal to one-third (1/3) of the total indebtedness then due. A photocopy of this contract shall be considered as valid as the original.

Katrina A. Thatch, DDS, PLLC

3610-A Boulevard

Colonial Heights, VA 23834

Patient's signature: Date:

Please select which scenario applies to you	