Bowman Psychiatric, A Medical Corp.

9777 Wilshire Blvd., Ste.707
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Ph: (310) 276-4003/ F: (310) 276-4073

AUTHORIZATION FOR RELEASE OF FINANCIAL DATA

Please fill this form out if someone, other than yourself, will be paying for your visits.

Responsible Party: _____ Relationship to patient: _____

Address: _____ Phone #: _____

Patient's name: _____ Birth Date: _____

☐ I hereby authorize Bowman Medical Group to furnish the above named individual or company all financial data including **scheduled appointments**, **late cancellations** and **no shows**.

This authorization is specifically for financial data only. No medical data will be furnished without written consent by the patient.

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon and if not earlier revoked it shall terminate one year from date of consent without express revocation.

The patient may receive a copy of this authorization if requested.

_____ _____
Date Patient Signature

_____
Parent or Legal Guardian