HIPAA WAIVER AND RELEASE

1. My name is _____ and I am hiring Bill Equity, LLC ("Bill Equity") for the purpose of negotiating a reduction in or correction of the following medical bills or hospital bills (the "Medical Bills"):

2. Patient Name: _____

Description of Bill (account number, provider)

a._____

b._____

c. _____

3. I am sending the above-referenced Medical Bills to Bill Equity by:

☐ U.S Mail

☐ Scanned and E-Mailed PDF

☐ Facsimile

And I authorize Bill Equity to use the Medical Bills and other HIPAA-protected information for the sole and limited purpose of endeavoring to negotiate a reduction or correction in the Medical Bills.

4. I understand that the information I send to Bill Equity covered by this waiver may include billing records, statements, insurance claim forms, itemized bills, records of billing, explanations of benefits and denials of benefits (the "Billing Materials").

5. I understand that Bill Equity might be asked by the billing agency questions about my ability to pay my medical bills, and questions about how many medical bills I have had during a specific time period. I agree to provide Bill Equity with honest answers to those questions, and will indemnify Bill Equity and its agents and employees in the event false information is provided.

6. I agree that Bill Equity may use the Billing Materials in connection with negotiating discounts for the Medical Bills or having corrections made to the Medical Bills.

7. I have carefully considered the Billing Materials and I understand that I have the choice to not disclose sensitive medical information. If I am unwilling to disclose certain parts of the medical information contained in a Medical Bill, I can contact Bill Equity for other options that might still enable Bill Equity to negotiate my Medical Bill.

8. I understand that the Billing Records and the authorizations contained herein are given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived, to the extent applicable.

9. I understand that I have the right to revoke this authorization in writing at any time, except to the extent information has already been released in reliance upon this authorization.

10. I understand that the information released in response to this authorization may be re-disclosed to other parties by the billing companies or to other employees or independent contractors of Bill Equity.

11. The authorization shall be in full force and effect until two (2) years from the date of execution, after which time this authorization expires.

Print Patient Name: _____

_____

Signature of Patient or Legally Authorized Representative (See 45CFR Section 64.508(c)(1)(vi))

Date: _____

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Name and Relationship of Legally Authorized Representative to Patient, if This Waiver is Being Signed by Someone Other Than Patient:

Print Representative Name: _____

Describe Relationship: _____

Date: _____