Financial Account Information Release Form

Patient: _____ Date of Birth: _____

Partner: _____ Date of Birth: _____

Release of Information

By signing below, I authorize the following medical provider to disclose any and all information regarding my account including, but not limited to, payment history and billing statements/invoices, in my name (or my Partner's name, if applicable) to Parental Hope, Inc. for the purpose of applying for the Parental Hope Family Grant.

Name of Medical Provider:_____

Address:_____

Physican:_____

This Release will remain in effect until terminated by me in writing.

Signature of Patient:_____ Date: _____

Signature of Partner:_____ Date:_____

Witness:_____ Date:_____