

# Sample Authorization for Medical Billing

[Your Name]

[Your Address]

[City, State, ZIP Code]

[Date]

To Whom It May Concern,

I, [Your Name], hereby authorize [Medical Billing Company's Name] to process and handle medical billing on my behalf for services rendered at [Healthcare Provider's Name], during the period of [Start Date] to [End Date], or until further notice.

I grant permission for [Medical Billing Company's Name] to submit claims, invoices, and coordinate billing matters.

Please consider this letter as my formal authorization for medical billing.

Sincerely,

[Your Signature]

[Your Printed Name]