Winneshiek Medical Center

901 Montgomery Street
Decorah, IA 52101

Authorization to Release Billing Information

Date of Request _____ Account # _____

Patient Name _____ Date of Birth _____

I give authorization for the following person(s) to gain information about my account at Winneshiek Medical Center.

Name _____

Relationship to Patient _____

Phone Number _____

Name _____

Relationship to Patient _____

Phone Number _____

Name _____

Relationship to Patient _____

Phone Number _____

This authorization will be valid until December 31st of this year. After that time, you will need to fill out a new authorization form.

Patient or Legal Guardian signature _____

Date _____