Healthcare Bill Payment Authorization

Date: [Insert Date]

To Whom It May Concern,

I, [Your Name], residing at [Your Address], authorize the payment of my healthcare bills to:

Provider Name: [Provider's Name]
Provider Address: [Provider's Address]
Account Number: [Your Account Number]

This authorization includes any medical bills, invoices, and charges incurred for services received.

Authorized Amount: [Insert Amount]
Payment Method: [Insert Payment Method]

Please contact me at [Your Phone Number] or [Your Email Address] if you require further confirmation or information.

Thank you for your attention to this matter.

Sincerely,

[Your Name]
[Your Signature (if sending a hard copy)]