Third-Party Payment Authorization

Date: [Insert Date]

To: [Medical Provider's Name]

Address: [Medical Provider's Address]

Re: Authorization for Third-Party Payment

Dear [Medical Provider's Name],

I, [Patient's Name], hereby authorize [Third Party's Name] to make payments on my behalf for medical bills incurred at your facility. This authorization applies to the charges related to services provided on or after [Insert Date].

Patient Information:

- Name: [Patient's Name]
- Date of Birth: [Patient's DOB]

Third-Party Information:

- Name: [Third Party's Name]
- Address: [Third Party's Address]
- Phone Number: [Third Party's Phone Number]

By signing below, I acknowledge that I understand this authorization and that I am giving my consent for [Third Party's Name] to handle all related payments.

Signature: _____

Name: [Patient's Name]

Date: [Insert Date]

Please do not hesitate to contact me at [Your Phone Number] or [Your Email] if you require any further information.

Sincerely,

[Patient's Name]

[Patient's Address]