Flourish, LLC

INSURANCE BILLING AUTHORIZATION

By signing this authorization, I authorize Dr Jaymie Mackler to use and/or disclose certain protected health information, (PHI) about me to or for the party or parties listed below. This authorization permits Dr. Jaymie Mackler to use or disclose to QMBS, Quality Medical Billing Services the following individually identifiable health information: dates of service, services and treatments rendered, and diagnoses.

Catherine Holmes
Quality Medical Billing Services
1404 SE 151st Ave.
Portland, OR 97233

I have the right to revoke this authorization in writing except to the extent that Dr Jaymie Mackler has acted in reliance upon this authorization. My written revocation must be submitted to Dr. Mackler's Privacy Officer at 8301 NE Hazel Dell Ave 98665.

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian