

# LETTER OF REPRESENTATION

**To: All Creditors/Creditors' Representatives/Collection Agencies.**

I hereby duly authorize, empower and appoint CLERKIE MONEY LLC, including any of its attorneys, debt settlement negotiation staff and other parties it may designate as my Attorney-in-Fact, to communicate with any of my Creditors, Creditors' Representatives and/or Collection Agencies and obtain any requested information regarding any accounts or debts I may owe, including but not limited to the balance of my account, payment history, credit rating, verification of the account and any other information necessary to make satisfactory arrangements for the payment/settlement of such accounts or debts. Also to make good faith settlement and/or payment offers on my behalf to settle such accounts or debts. This Limited Power of Attorney shall remain in force until or unless modified or rescinded in writing.

Client's Signature: \_\_\_\_\_

Date:

Name:

DOB:

Address:

# **AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all the information requested may invalidate this authorization.

Name of Patient:

## **USE AND DISCLOSURE OF HEALTH INFORMATION**

I hereby authorize \_\_\_\_\_ to release to Clerkie Money LLC with an address of 619 7th St, San Francisco, California, 94103, the following information:

All health information pertaining to my medical history, mental or physical condition and treatment received.

A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

## **PURPOSE**

Purpose of requested use or disclosure is of the Patient's request.

## **EXPIRATION**

This authorization expires 364 days after today's date.

## **MY RIGHTS**

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to the following mailing address 619 7th St, San Francisco, California, 94103.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosures of it unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

## **SIGNATURE**

**Signature:** \_\_\_\_\_

By

**Date:**

## **NOTES FOR PROVIDERS THAT USE THIS FORM**

If the purpose of the authorization is to use the information for marketing by a third party that remunerates the provider, a statement to this effect must be included in this authorization form.

If the purpose of the authorization is for the sale of protected health information (PHI), this form must state whether the PHI can be further exchanged for remuneration by the initial recipient.

A provider that discloses health information pursuant to an authorization must communicate any limitation contained in the authorization to the recipient [Civil Code Section 56.14]. The required notification may be accomplished by giving the recipient a copy of the authorization form.