AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
UNDER HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

1. The patient named below hereby executes this authorization in compliance with the Federal Health Insurance Portability and Accountability Act, HIPAA, 45 CFR 164.104:

PATIENT: _________________________________ DOB: ___________ SSN: ________________________

2. This authorization is directed to the following healthcare provider (including its agents, employees and associates):
PROVIDER: ______________________________

3. The above-named healthcare provider is requested to release the protected health information (PHI) that is described below, to ____________________________________

4. The Protected Health Information released herein is specifically as follows:
All medical information of any nature whatsoever, from any source whatsoever, which is requested by my attorneys. If you are a physician or out-patient clinic, you are authorized to send your entire chart upon their request, including not only the records dictated or written-up by you, but also insurance records, handwritten notes, telephone memoranda, outside records, correspondence, or any other tangible item maintained in my chart. The records include but are not limited to the following items:

Complete Medical Chart
Most recent History and Physical ______All From______ To___________
Most recent discharge summary ______All From______ To___________
Initial Patient Paperwork/Questionnaires______All From______ To___________
Office Notes and Reports ______All From______ To___________
Physical Therapy Records and Notes ______All From______ To___________
Laboratory Reports and Results ______All From______ To___________
X-ray and Imaging Reports ______All
Consultation Reports from any other physicians ______All
Final Narrative Reports and Impairment Ratings ______All
Itemized Bill for Services Rendered ______All ______ Total Charges ______Balance

Other
I__ **do** __**do not** authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. Such information may not be re-disclosed by the recipient without my specific consent.
I__ **do** __**do not** authorize disclosure of information which refers to treatment or diagnosis of mental health.
I__ **do** __**do not** want to review this information before it is released. I understand that reviews must be supervised by hospitals and may be supervised by doctors and/or other medical facilities.
I__ **do** __**do not** authorize disclosure of information which refers to HIV test results or infection status.
I understand that I am entitled to a copy of this authorization form.

REQUIRED DISCLOSURES - 45 CFR 164.508(c)

A. This protected health information is to be used for the following purpose: A Civil legal claim or proceeding.
B. This authorization may be revoked by a signed and properly dated written revocation delivered to the health care provider named above, provided that this release cannot be revoked as to protected health information that had been released previously, in reliance on this document.
C. The undersigned acknowledges that a refusal to sign this form will not result in a denial of health care by the hospital or any other health care provider and that this release has not been coerced by a health care entity or any of it's business associates.
D. The undersigned acknowledges that once the PHI is disclosed, it may be re-disclosed to individuals or organizations that re not subject to the federal private regulations such as expert witnesses, litigants, insurance companies, and even may become public record if filed with a court of law.
E. This authorization is valid for a period of twelve (12) months from the date of signing, unless earlier revoked in writing.

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Note: A copy of this authorization shall be treated as an original.

Patient's Name or Representative: _______________________________________ Date: _________________

Relationship to Patient: _________________________

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