

**HIPAA PRIVACY
AUTHORIZATION FOR RELEASE OF INFORMATION**

YOUR INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	SOCIAL SECURITY NUMBER:	DATE OF BIRTH:

Person/Organization Providing the Information <i>45 C.F.R. § 164.508(c)(ii)</i>	Person/Organization to Receive the Information <i>45 C.F.R. § 164.508(c)(iii)</i>

Description of the Information to be Released (Provide a detailed description of the specific information to be released) <i>45 C.F.R. § 164.508(c)(i)</i>
<p>I authorize the release, disclosure and redisclosure of:</p> <ol style="list-style-type: none"> 1. All medical records, bills, information and/or opinions, without limitation, including all registration sheets, discharge summaries, ER records, H&P, consults, progress notes, discharge instructions, lab results, radiology results, EKG/ cardiology testing results, operative reports, implant information, pathology reports, medication lists, imaging studies, behavioral health information, substance abuse information, human immunodeficiency virus (HIV) information, all information relating to personal and sensitive documents, all information including concerning all medical, psychological, psychiatric conditions, treatment tests, diagnosis and/or opinions, drug tests, screenings and/or results and diseases of any nature. 2. All financial information including all financial records, bills, w-2's, 1099's, tax records, tax returns, tax reports and/or tax schedules. 3. All insurance information, including the release and disclosure of all health insurance information and policies, automobile insurance information and policies, homeowner's insurance information and policies, including all policy endorsements, declaration sheets, applications, waivers, elections, underwriting file, claims file, statements, photographs, medical files, medical payment schedules and investigations. 4. All information from all entities which may have potential liens with regard to the subject litigation, including all information and files relating to welfare, medicare, medicaid, public assistance, workers compensation and/or self funded employee welfare benefit plans to which I belong within the meaning of ERISA, 29 U.S.C. §1001, et seq., including the disclosure of all relevant portions documenting the ERISA plan, evidence that the ERISA plan is fully self funded and all information relating to any and all subrogation liens.

Description of Each Purpose for the Use or Release of the Information
(Provide a detailed description of the activity for which the information will be used)
[45 C.F.R. § 164.508(c)(iv)]

This authorization will be used for litigation purposes.

Will the health plan or provider receive money for the release of this information?
[45 C.F.R. § 164.508(a)(3)]

Yes No

Unless otherwise revoked, this authorization for the release of the above information to the above named persons/organizations will expire at the conclusion of the litigation or within 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete and update the request, whichever date is later. [45 C.F.R. 164.508(c)(v)]

I understand:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. [45 CFR § 164.508(c)(2)(i)]
- I have the right to revoke this authorization by sending a notice stopping this authorization to the medical provider listed above. The authorization will stop on the date my request is received. [45 C.F.R. § 164.508(c)(2)(ii)]
- I understand the Notice of Privacy Practices provides instructions should I choose to revoke my authorization and I understand that a revocation does not apply to information already released in response to this authorization. [45 C.F.R. § 164.508(c)(ii)]
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. [45 C.F.R. § 164.508(c)(2)(iii)]
- I understand I have the right to receive a copy of this authorization.

Signature:

Date:

X

If executed by a parent or representative, please state relationship and/or authority to execute to the above request:

[45 C.F.R. § 164.508(c)(vi) & 45 CFR 164.508 (c)(1)(vi)]