MORGAN & MORGAN

November 10, 2022

11785192
Mr. Donhav Noname
1234 Main St
Las Vegas, NV 00000

Re: Preston Blair v. Andrew East TEST MATTER DO NOT EDIT
Date of Incident: 4/22/2021

Dear Mr. Donhav Noname:

Thank you for trusting our firm with your case.

Enclosed please find a medical authorization for you to sign and return to our office. This authorization will allow us to gather medical records and bills to be used as evidence in your case.

If you were not the patient, please be sure to sign in the location for the guardian or representative.

Thank you for your cooperation.

Sincerely,

Preston Blair

# MORGAN & MORGAN

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

***** Records Requested in Electronic Format per 45 CFR 164.524(c)(2)(ii)***

1. The undersigned patient, named below, hereby executes this authorization in compliance with the Federal Health Insurance Portability and Accountability Act, HIPAA, 45 CFR 164.104, 45 CFR 164.508 and 45 CFR 164.524.

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

_____

_____

_____

3. The above-named healthcare service provider is requested to release the protected health information (PHI) that is described below, to the patient's attorney:

Morgan & Morgan
80 Monroe Avenue, Suite 900
Memphis, TN 38103
Telephone: _____
Attn: _____

4. The protected health information released herein is specifically as follows:

All medical information of any nature whatsoever, from any source whatsoever, which is maintained by you in your records regarding the referenced patient and 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.

If you are a hospital, you are authorized to release my complete records including x-rays or similar studies, office notes, face sheets, discharge summaries, history and physical, consultation notes, intra-operative records, anesthesia records, operative reports, recovery room, pathology reports, medication administration records, EKG reports, EKG strips, EEG reports, EEG strips, therapy notes, orders, progress notes, laboratory results, nurses notes, vital sign sheets, intake/output records, reports of all x-rays, mammograms, CT scans, MRIs or PET scans, emergency room records, transfer records, operative reports, anesthesia records, admitting summary, discharge summary, discharge instructions, personal property list, in-patient records, out-patient records, clinic records, correspondence, photographs, videotapes, telephone messages, computer generated information, medical bills, pharmacy and drug records, health insurance forms, insurance claim forms, insurance payment forms, Medicaid or Medicare records, concerning any medical treatment that I have received from you, at your institution, or which you keep in the regular course of business. I hereby authorize release of all records regarding mental health, psychiatric, chemical dependency or HIV. A photo static copy of this authorization shall be as valid as the original.

**In accordance with the provisions of 45 CFR §164.524(c)(3)(ii), I specifically request that copies of my medical records be transmitted to my attorney identified in paragraph 3 above, as my designee, and mailed to the address shown in that paragraph, and that the RECORDS BE PROVIDED IN ELECTRONIC FORMAT (PDF format on CD media), as required by 45 CFR §164.524(c)(2)(ii).**

*Note: a Copy of this Authorization Shall Be Treated as an Original*

***** Records Requested in Electronic Format per 45 CFR 164.524(c)(2)(ii)***

The records include, but are not limited to, the following items:

____ 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
____ X-ray and Imaging Reports ____ All
____ Consultation Reports from any other Physicians ____ All
____ Entire Record and/or Chart
____ Final Narrative Reports & Impairment Ratings
____ Itemized Bill for Services Rendered ____ Total Charges _____ Balance
____ Medicare/Medicaid, ERISA, group health, medical, worker's compensation, etc., insurance and or collateral source benefits providers' records (i.e., medical records, medical reports, insurance and submission claim forms, payout records, benefits and policy information, subrogation language, claims of lien, etc.)
____ Other _____

***Always include patient intake forms and any documents related to the billing and payment for services.

**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 healthcare provider named above, provided that this release cannot be revoked as to protected health information that had been previously released in reliance on this document.

C. The undersigned acknowledges that a refusal to sign this form will not result in a denial of healthcare by the hospital or any other healthcare provider and that this release has not been coerced by a healthcare entity or any of its business associates.

D. The undersigned acknowledges that once the PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, insurance companies, and even may become public record if filed with a court of law.

E. This authorization will be effective for the entire duration of the legal matters related to the accident which involved the patient and occurred on 4/22/2021, unless earlier revoked in writing.

_____ _____
Patient's Signature | Signature of Authorized Representative (Parent, Legal Guardian or Personal Representative)

Donhav Noname _____
Patient's Name | Witness

11/7/1990 _____
Patient's Date of Birth | Dated

111-22-3333
Patient's Social Security Number

*Note: a Copy of this Authorization Shall Be Treated as an Original*