CONSENT TO ACCESS ON-LINE MEDICAL PORTAL

We cannot litigate and prove your case until we receive and review your medical records. Sometimes, especially during COVID, it can take months to get the hospital or health care provider to send us your medical records. Meanwhile, while we wait, the same records we are requesting are often immediately available (usually free of charge) on your health care provider's on-line portal.

In an effort to access your medical records more efficiently and without waiting on the provider to send them, we are requesting access to your On-Line Medical/Health Information web portal to obtain the records necessary for your potential claim. In order to access your private health information, it is vital that we receive consent in order to obtain these records on your behalf.

By signing this form, I authorize Andrus Wagstaff and Wagstaff Law Firm, including employees and representatives, to obtain records on my behalf via my personal medical records portal with my medical facility. I acknowledge and understand that this includes all personal health information relating to my potential claim.

I further understand that this consent is only valid during the course of my litigation case with Andrus Wagstaff and Wagstaff Law Firm and will be revoked at the close of my case and/or in the event representation is withdrawn either by myself or by Andrus Wagstaff and Wagstaff Law Firm.

ON-LINE MEDICAL PORTAL INFORMATION

Full Name: Jerry Dewayne Hunter

Date of Birth: 08/05/1945 Place of Birth: Tipton County Tennessee

Medical Facility Portal Website: NA

Portal Username: NA

Portal Password: NA

Sincerely,

Aimee Wagstaff, Esq.
Your Attorney

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: Jerry Dewayne Hunter Health Record No.: _____

Date of Birth: 08/05/1945 Social Security No.: 412-72-1748

Home Phone No.: _____ Work Phone No.: _____

I authorize_____(facility/physician) to disclose the above named individual's health information obtained in the course of my evaluation and/or treatment to:

WAGSTAFF LAW FIRM
940 Lincoln Street
Denver, CO 80203

*Purpose: At the request of the individual

Type of Access: Copies of Medical Information Checked Below

Entire Medical Record: Dates Requested*:_____through_____

OR , Specifically:

_ Discharge Summary
_ Emergency Room Records
_ History and Physical
_ Consult Reports
_ Operative Reports
_ Rehabilitation Services
_ Lab Workups
_ Imaging/Radiology
_ Nursing Notes
_ Medication Records
_ Psychological Records
_ Psychiatric Records
_ Progress Notes
_ Physician Orders
_ Pathology Reports
_ Face Sheets
_ Detailed Billing**
_ UB92

*If blank, this request covers all records for the entire period the authorized facility/physician evaluated or treated the patient.

**Forward to patient accounts for processing

I consent to the release of information regarding psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment, and/or any communicable disease including HIV (AIDS) testing and/or results.

I understand that I have the right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing and present my

written revocation to the person or department responsible for health information management. I understand that the revocation will not apply to information that has already been released in response to this authorization. Regardless, this consent shall become invalid and expire 180 days from the date of my signature.

I understand that information disclosed by this authorization may be re-disclosed by the recipient of your protected health information. Such re-disclosure will no longer be protected by this facility's authorization. I understand that if the organization receiving this information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. I understand that I have a right to receive a copy of this authorization - and I do / do not wish to receive a copy. I understand that a copy or facsimile of this authorization is as valid as the original.

I understand that my healthcare and the payment of my healthcare will not be affected by my signature on this authorization. I understand my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

I hereby release the provider (facility/physician) from any and all legal liability and injuries that may arise from the release of this information to the parties named above. The information that I am requesting may be sent by U.S. Mail service, facsimile, UPS or other means in accordance with the policy of the provider.

The provider (facility/physician) may honor a photocopy or facsimile of this document.

I HAVE READ THE ABOVE OR HAVE HAD IT READ TO ME AND I AUTHORIZE THE DISCLOSURE OF THE PROTECTED HEALTH INFORMATION AS STATED.

Jerry Hunter

Signature of Patient or Legal Representative

Date

Relationship to Patient

To the Party receiving this information:

This information has been disclosed to you from the records whose confidentiality may be protected by state and/or federal law. Certain regulations prohibit you from further disclosure of it without the specific written consent of the person to whom it pertains, or otherwise, as permitted by such law and regulations. A general authorization for the release of such medical or other information is not sufficient for this purpose. Fees will be charged for the release of information in accordance with the law.