AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: Don Sargent Social Security Number: 330480187

Date of Birth: 08/26/1950

Authorized Medical Provider to Use or Disclose Information (including its agents, employees and associates):

I hereby authorize the use and disclosure of my protected health information related to my care, treatment and/or services otherwise known as "Protected Health Information" (PHI), as permitted by the Federal Health Privacy Law (HIPAA), as detailed below:

Information to be used or disclosed:

Dates of Services(s): _____to _____

Specific Description/Type of PHI: All PHI in medical record; all admission form, office notes, reports, opinions, x-rays, MRI, CT or other scans, tests, operative report(s); admission forms, dictation reports, physician orders, intake/outtake/clinical tests/ medication sheets; operative information, Cath, lab reports, special test/therapy, rhythm strips, nursing information, transfer forms, ER information, itemized bill including, but not limited to HCFA or UB-92, and all records to be provided to you by other medical providers/facilities.

☐ All Medical Records ☐ Itemized Billing ☐ Radiology/Imaging

☐ Abstract of Medical Records	☐ ER Records	☐ Operative Reports
☐ Admissions/Face Sheet	☐ Fetal Monitoring Strips	☐ Pathology Reports
☐ Ambulance Records	☐ Gastrointestinal (GI) Lab Reports	☐ Pharmacy Records
☐ Attending Physician's Statement	☐ History & Physical Reports	☐ Photographs
☐ Autopsy Reports	☐ Implant/Explant Logs	☐ Physical Therapy Records
☐ Anesthesia Records	☐ Intra-Operative Nursing Notes	☐ Pre-Op Standing Orders
☐ Chart Stickers	☐ Laboratory Reports	☐ Product ID/Implant Label
☐ Consultation Reports	☐ Nurse's Notes	☐ Psychiatric Records
☐ Discharge Summary	☐ Nurse's Medication Records	☐ Radiology/Diagnostic Reports
☐ Doctor's Records	☐ Office Notes	☐ Recovery Room Records

☐ Other_____

Information May Be Disclosed/Released to: **National Record Retrieval, 101 East Carmel Dr. Ste 111, Carmel, IN 46032**

Reason(s) for Use or Disclosure): (At the request of the Patient) To allow my attorney representing me from **Wagstaff Law Firm** to adequately and properly investigate and handle my potential claim.

Pursuant to the HITECH Act, 42 U.S.C.A. 17935(e)(1), and its implementing regulations, 45 CFR 164.524(c)(40(i) we are requesting, in an electronic format only, an accurate and complete copy of the above referenced patient's medical records from [insert date] to [insert date]. Please be aware that the HITECH Act applies to requests by third-parties, like our law firm, just as it applies to requests by patients: "if requested by an individual, a covered entity must transmit the copy of protected health information directly to another person designated by the individual." (see Federal Register January 25, 2013 Vol. 78 No. 17, Page 5634). We are not requesting paper copies. The HITECH Act and its regulations do not allow you to bill for paper copies when an electronic copy has been requested. I will not hesitate to file a complaint with the Department of Health & Human Services (HHS) if you violate the law by improperly applying the paper copy rate for electronic records. Please also provide a copy of your statement of charges. This request includes all records obtained from and correspondence to and from other health care providers or sources.

Authorization will expire two (2) years from the date of signature unless revoked or terminated by Patient. A photocopy of this authorization is to be considered as valid as the original.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.
7. I acknowledge and hereby consent to the release of alcohol, drug abuse, psychiatric, genetic testing, HIV testing, HIV results or AIDS information.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient or Legal Representative

Date

Relationship to Patient