AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may be subject to re-disclosure and may no longer be protected by federal privacy regulations, including HIPAA. I hereby release the organization providing this information from any legal responsibility or liability for disclosure of this information to the extent indicated and authorized herein.

Patient Name:_____ **SS #**_____

Patient Address:_____ **Date of Birth:**_____

Persons/Organizations providing the information:_____

Persons/organizations receiving the information: Law Offices of Michael A. DeMayo, L.L.P.

Specific description of information, covering health care from _____ **to**_____:

☐ Complete health records and bills, excluding all images (x-rays, photographs, etc.)

☐ Other (please specify)_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus(HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse, in addition to information related to sickle cell anemia.

This information may be disclosed to and used by the following individual or organization:

Law Offices of Michael A. DeMayo, L.L.P.

Address: Post Office Box 34426, Charlotte, NC 28234

for the purpose of: *Investigation of an injury claim until the claim has been resolved*

REVOCATION OF ALL PRIOR MEDICAL AUTHORIZATIONS

I, hereby revoke all previous authorizations given by me for the release of medical information for any reason or purpose whatsoever, and specifically request that no medical information of any nature be shown, discussed, or released to any other party other than the Law Offices of Michael A. DeMayo, L.L.P. I understand I have the right to revoke this authorization, in writing, at any time. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

Unless revoked, this authorization will expire the earlier of two years from the date of execution below or upon the closing of my legal matter by the Law Offices of Michael A. DeMayo.

I understand that authorizing the disclosure of this health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Director at the above named facility.

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, Relationship to Patient

Signature of Witness