TO:

Regarding Patient (First and Last Name)

Patient Date of Birth **Patient Social Security Number**

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

1. All Medical Records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurses' notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires, histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

2. All physical, occupational and rehab requests, consultations and progress notes.

3. All disability, Medicaid or Medicare records including claim forms and benefit denials.

4. All employment, personnel or wage records.

5. All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

6. All pharmacy/prescription records including NDC numbers and drug information handouts /monographs.

7. All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period:

_____ to _____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed to my attorney to aid in the recovery of damages resulting from a personal injury.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.
You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply

I understand the following: CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at anytime, except to the extent information has been released in reliance upon this authorization.

b. The information released in response to this authorization may be re-disclosed to other parties.

c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires, or until this expiration date: _____.

_____ _____

Signature of Patient **Date (45 CFR § 164.508(c)(1)(vi))**

_____

Name and Relationship of Legally Authorized Representative to Patient
(45 CFR §164.508(c)(1)(iv))

_____ _____

Witness Signature Date