Suffolk University
Law School

Accelerator Practice

120 Tremont Street, Suite 110
Boston, Massachusetts 02108
(617) 573-8644; (617) 742-2139 (fax)

Authorization for Release of Protected Health Information (HIPAA)

TO:

_____
(Name/ Organization)

_____
(Address)

I, _____, _____ (DOB), hereby give you my permission to disclose my protected health information, as described below, to my legal representative, _____, and his/her associates at the Suffolk Law School Accelerator to Practice.

I give permission to disclose the following information (please **initial** all that apply):

_____ Records, opinions, reports, X-rays, lab test results, information relating to testing, diagnosis or treatment, and any other information or documents relating to services provided from _____ to _____.

_____ Psychotherapy records, reports, notes, and information relating to diagnosis and treatment. **(Note: Permission to release psychotherapy notes must be on a separate form.)**

_____ Other: _____

By giving permission to disclose this information, I also give permission to disclose (please initial all that apply):

_____ Any and all information and records about testing, diagnosis or treatment for HIV/ AIDS or sexually transmitted diseases it may contain.

_____ Any and all information and records about drug or alcohol use, testing, diagnosis or treatment it may contain, which are protected by federal

confidentiality rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

I request disclosure for the purpose of helping with my legal representation. I waive any doctor-patient or counselor-patient privilege with respect to this request in favor of my legal representative.

I understand that:

- This authorization is voluntary. If I refuse to sign it, my health care treatment, payment, health plan enrollment, and eligibility for benefits will not be affected.
- I may cancel this authorization in writing at any time by sending a letter to my healthcare provider named above, or to _____ ,of the Suffolk Law School Accelerator to Practice at 120 Tremont Street, Suite 110, Boston, MA 02108.
- If I cancel this authorization, the person(s) or organization(s) listed above cannot take back any information that they released while they had my permission to do so.
- Information disclosed under this authorization may not be protected by health information privacy laws if it is re-disclosed.

A copy of this signed authorization shall have the same force and effect as the original.

This authorization will automatically expire in six (6) months unless otherwise specified: _____ (date or event), or unless I specifically cancel this authorization in writing at a prior time.

I have read and understand this authorization. I confirm that it correctly states my instructions to disclose my protected health information.

_____

Signature of patient or representative

Dated: _____

If signed as personal representative, relationship: _____