HIPPA AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: ____

Healthcare Provider

____

Street Address

____

City, State, and Zip Code

RE: Patient Name: ____

Date of Birth:______________________ Social Security Number:____________________

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

☐ 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, nurse's notes, social worker records, clinical records, treatment plans, admission records, and discharge summaries; requests for and reports of consultations; documents; correspondence test results; statements; questionnaires/histories; photographs; videotapes; telephone messages; and records received by other medical providers.

☐ All mental health records, including but not limited to, questionnaires, office notes, doctor's notes, therapy notes, test results, diagnostic reports, and treatment reports.

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

☐ All disability, Medicaid or Medicare records, including claim forms and record of denial of benefits.

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

☐ All pharmacy/prescription records including NCD numbers and drug information handouts/monographs.

☐ 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, or human immunodeficiency virus, and alcohol and drug usage. I authorize the release or disclosure of this type of information.

The protected health information is disclosed for the purpose of legal representation in matters now pending in court or which I anticipate will soon be filed in court.

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 restriction of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following persons:

Name:

Address:

I understand the following: (*See* 45 CFR 164.508(c)(2)(i-iii))

A. I have the right to revoke this authorization in writing at any time, 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 upon 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 for three years from the date of execution, at which time this authorization expires.

_____________________________________ ___________________________

Signature of Patient or Legal Representative Date

____

Name and Relationship to Patient

_____________________________________ ___________________________

Witness Signature Date