AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND OTHER RECORDS

NAME: ____________________________________ DOB: _____________________ SSN: ______________________________

I HEREBY GRANT PERMISSION TO AND AUTHORIZE THE USE OR DISCLOSURE OF THE ABOVE NAMED INDIVIDUAL'S RECORDS AS DESCRIBED BELOW TO THESE DESIGNATED ENTITIES:

and/or: ______________________. ____

THE FOLLOWING INDIVIDUAL(S), MEDICAL PROVIDER(S), AND/OR ORGANIZATION(S) ARE AUTHORIZED TO MAKE THE DISCLOSURE:

1. ______________________________ 5. ______________________________

2. ______________________________ 6. ______________________________

3. ______________________________ 7. ______________________________

4. ______________________________ 8. ______________________________

DATES REQUESTED: _____________________, up to and including, the present date.

Any and all, but not limited to, the following information are to be disclosed – NO EXCLUSIONS:

1. Complete and Entire Medical File including, but not limited to: Medical Reports, Records/Notes, Itemized Billing, correspondence, photographs, X-Rays/diagnostic studies, diagnostic films, laboratory results, information regarding HIV/AIDS, sexually transmitted diseases or other communicable disease information, references to drug or alcohol use, and mental health treatment, etc.;

2. Personnel, Attendance, Employment, Payroll, Wage Records, School Records and Transcripts, etc.;

3. Insurance Records, including all Claims, Itemized Billing, Correspondence, Payments and all documents within the file, etc.;

4. Traffic Accident Reports, Police Photographs, and Investigation regarding any criminal and/or civil litigation matter, etc.;

PURPOSE: The above information is being obtained to assist said authorized entities in evaluation of my claim for benefits or damages. A copy or facsimile of this document shall be considered as effective and valid as the original.

I understand I have the right to revoke this Authorization at any time. I understand if I revoke this Authorization I must do so in writing. 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. Unless otherwise revoked, this Authorization will expire on the following date, event, or condition: ________ **TO CONCLUSION OF CLAIM** ________. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand that authorizing the disclosure of this Health Information is voluntary and that I am entitled to a copy of this Authorization and acknowledge receipt of a copy thereof. I can refuse to sign this Authorization. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that signing this authorization may not condition treatment, payment, enrollment or eligibility for benefits.

____ Date: ______________________________

Patient/Natural Parent/Guardian/Legal Representative

SUBSCRIBED AND SWORN TO before me

This day ________ of ________________, 20______.

____

NOTARY PUBLIC of Said State and County