AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(In Compliance with 45 C.F.R. § 164.508)

PATIENT NAME: ____

DATE OF BIRTH: ____

1. This will authorize my attorneys, **ROSSETTI & DEVOTO**, or their representatives, to inspect, copy or obtain wage and employment records, police and fire reports, medical records, hospital records or any other information they may request in connection with my case. The said attorneys represent me and your full cooperation with them is respectfully requested.

2. You will please permit them to inspect, copy or obtain all records pertaining to me or you may furnish such copies to them. I agree that you may accept a photocopy of this authorization.

3. Kindly consider this also as authorization pursuant to any State or Federal Privacy Acts.

4. 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.

5. I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the 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 one year from the date of this disclosure.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR §164.524.

7. 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.

8. **Please <u>do</u> <u>not</u> disclose any information concerning me to any insurance adjuster or other persons, firm, or organization without written authority from me or my attorneys.**

9. **Under no circumstances does this authorization permit any ex parte contact by anyone on behalf of the defendants, his agents, his insurance carrier or law firm.**

______________________________	____________________
Signature of Patient or Legal Representative	Date
______________________________	____________________
If signed by Legal Representative, Relationship to Patient	Signature of Witness