AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(HIPPA COMPLIANT)

Patient Name:
Date of Birth:
S.S. #:

I hereby authorize the below listed physician/medical provider/hospital to release ANY AND ALL RECORDS IN THEIR POSSESSION PERTAINING TO ME including but not limited to, medical office, and treatment records, office notes, treatment, examination and consultation reports, diagnostic test results, X-Ray, MRI and CT Films and Reports from the following time period:

__________ to __________

PROVIDER NAME AND ADDRESS:

This information may be disclosed to:

For the purpose of: Litigation

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 and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. 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 in six months or on the following date:
Month ____ ___, Year _______.

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.

If You Do Not Wish This Information To Be Released, Please Initial Here ________

I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164-524. 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.

______ ____________________

or Legal Representative Date

____________________ ____________________

If Signed by Legal Representative, Relationship to Patient Signature of Witness

DATED: ____________________