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

10:	Name of Healthcare Provider/Physician/Facility/Medicare Contractor	
	Street Address	
	City, State and Zip Code	
RE:	Patient Name:	
	Date of Birth: Social Security Number:	
record	I authorize and request the disclosure of all protected information for the purpose of and evaluation in connection with a legal claim. I expressly request that the designated custodian of all covered entities under HIPAA identified above disclose full and complete ed medical information including the following:	
D	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, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.	
D	All physical, occupational and rehab requests, consultations and progress notes.	
$\tilde{\mathrm{D}}$	All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.	
D	All employment, personnel or wage records.	
D	All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.	
D	All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.	
D	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 (AIDS), or human

immunodeficiency virus (HIV), and alcohol and drug abu of this type of information.	ise. I authorize the release or disclosure
This protected health information is disclosed for the follower.	owing purposes:
This authorization is given in compliance with the federal alcohol or substance abuse records of 42 CFR 2.31, the respecifically considered and expressly waived.	l consent requirements for release of estrictions of which have been
You are authorized to release the above records to the fol- the above-entitled matter who have agreed to pay reasona copies of such records:	lowing representatives of defendants in able charges made by you to supply
Name of Representative	
Representative Capacity (e.g. attorney, records requestor,	, agent, etc.)
Street Address	
City, State and Zip Code	
I understand the following: See CFR §164.508(c)(2)(i-iii)	
a. I have a right to revoke this authorization in writing information has been released in reliance upon thin the information released in response to this authorization.b. The information released in response to this authorization.	is authorization. orization may be re-disclosed to other
Any facsimile, copy or photocopy of the authorization s requested herein. This authorization shall be in force ar execution at which time this authorization expires.	
Signature of Patient or Legally Authorized Representative (See 4SCFR § 164.SOS(c)(I)(vi))	e Date
Name and Relationship of Legally Authorized Representations (See 4SCFR § 164.508(c)(1)(iv))	ative to Patient
Witness Signature	Date