HIPAA COMPLIANT AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name:_____

Date of Birth:_____ **Social Security No.:**_____

I authorize all medical practitioners, physicians, hospitals, clinics, nurses, custodians of records, or anyone else at:

Facility:_____
to disclose the protected records and health information identified below: See 45 CFR § 164.508(c)(1)(ii).

Such records and health information will be disclosed for the purpose of evaluation and use in litigation to:
_____**.** See 45 CFR § 164.508(c)(1)(i)(iii).
(law firm)

Such records and information are to be released to and exchanged between the law firm named above and:

DATASCOPE | 135 Paseo Del Prado Ave., Suite 37, Edinburg, Texas 78539 | 965/687-1122

and its agents, contractors, employees, representatives, affiliates, and assigns as necessary to fulfill the purpose of this authorization and request for release of information.

Dates of treatment requested:_____

Documents to be disclosed: All records, meaning every page in my record, including but not limited to: office notes, face sheets, discharge summaries, history and physical, consultation notes, intra-operative records, anesthesia records, operative reports, recovery room notes, pathology reports, medication administration records, EKG reports and strips, EEG reports and strips, therapy notes, orders, progress notes, laboratory results, nurses notes, vital sign sheets, intake/output records, x-ray reports, mammograms, CT scans, MRI's, PET scans, respiratory therapy records, nutrition records, social worker records, transfusion records, code sheets, consent forms, autopsy report, labor flow sheets, labor and delivery summary, delivery summary/report/note, fetal monitor strips, nursery records, emergency room records, transfer records, discharge instructions, personal property list, in-patient records, clinic records, correspondence, photographs, videotapes, telephone messages, computer generated information, medical bills, pharmacy and drug records, health insurance information, insurance claim forms, insurance payment forms, Medicaid or Medicare records, and medical narrative reports.

I understand the information to be disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), psychological or psychiatric treatment, behavioral or mental health services, genetic testing, sickle cell testing, and alcohol and drug abuse.

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

a. I have a 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 may be subject to re-disclosure by the law firm to other parties and may no longer be protected by the same rule that applied in the first instance.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
d. This authorization shall survive and not terminate upon my mental incapacity or legal disability.
e. **This authorization will expire 1 year from the date signed below.** See 45 CFR § 164.508(c)(1)(v).
f. A photocopy of this Authorization shall be treated in the same manner as the original.

_____ _____
Signature of Patient or Legally Authorized Representative See 45 CFR § 164.508(c)(1)(vi) **Date Signed**

_____
Relationship of Legally Authorized Representative to Patient See 45 CFR § 164.508(c)(1)(iv)