AUTHORIZATION TO COPY PROTECTED HEALTH INFORMATION

ALL blanks must be filled in for this Authorization to be valid

Patient Name: _____ aka: _____

Social Security Number (optional): _____ DOB: _____

Medical Provider: _____ Phone: _____

Address: _____ City: _____ State _____ ZIP _____

Requested by: _____ Phone: _____

Make disclosure to: _____ Phone: _____

Information to be disclosed: Provider is directed to make available for copying all medical records pertaining to the Patient listed above, including but not limited to treatment, hospitalizations, evaluations, testing, and surgeries. This includes all files or records for all injuries or conditions in Providers possession or under Provider's control that is held for any purpose with the following exceptions:

_____

(do not leave blank; if none, write "none")

I further authorize information to be disclosed by Provider if the box(s) below are checked:

- ❑ All billing records showing all charges, expenses costs and payments
- ❑ Original x-ray films
- ❑ Drug and alcohol abuse testing, evaluation and treatment
- ❑ Mental health information ***(a separate authorization is needed for psychotherapy notes)***
- ❑ Information regarding human immune-deficiency virus (HIV) or acquired immune deficiency syndrome (AIDS).

Purpose of the requested disclosure: To assist the requester and patient in establishing the liability, nature and extent of a claim for injuries and disabilities and to establish benefits, expenses, compensation and damages. The information provided may be disclosed by the requester to other parties or evaluating or treating physicians for the purpose of prosecuting or defending any claim for which the requester has been engaged to pursue or defend.

Expiration date: This authorization shall expire (specific date required) _____.

Limitations on disclosure by provider: This Authorization does not permit Provider to allow the copying of the records by any other copy service or business associate as defined by the Health Insurance Portability Accountability Act (HIPAA). This Authorization does not permit disclosure of my information to any person, entity, provider or insurance company other than the requester listed above.

Right to Revoke: The Patient or Patient's Representative has the right to revoke this Authorization at any time by submitting a signed written request to the Medical Provider listed above. Your revocation will be effective upon receipt, but will not be effective to the extent that actions to comply with the original request have already been taken, or if the authorization was obtained as a condition of obtaining insurance coverage.

A copy of this signed Authorization will be given to the Patient or Patient's Representative after it has been signed.

A copy of this Authorization is as valid as the original.

Date: _____ Signed: _____

Patient or Patient's Legal Representative (must provide legal papers)