AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Patient's PRINTED Name:	Birth date:	Social Security No:

I hereby authorize _____ to disclose protected health records obtained and/or created in the course of my evaluation and/or treatment to:

Type of Access Requested: _____Copies of Records _____Inspection of Records

Medical Records: (Entire Record or Selected Portions of PHI as indicated below)

Description:	**Date(s)**	**Description:**	**Date(s)**	**Description:**	**Date(s)**
( ) Entire Records ( ) Admission Form ( ) Physicians' Orders ( ) Labs ( ) Liver Function Tests/Results ( ) Medication Records ( ) Consultation Reports **(XX)Other: SEE ATTACHED REQUEST**		( ) Operative Reports ( ) Rehabilitation Services ( ) Pathology Report(s) ( ) Pathology Slide(s) ( ) Radiology Reports ( ) Radiology Films ( ) Nurses' Notes ( ) ER Records ( ) Other: _____		( ) Psychological Record(s) ( ) Psychiatric Record(s) ( ) History and Physical ( ) Discharge Summary ( ) Detailed Billing Records ( ) Itemized Statements ( ) Conditional Payments and/or Lien Information ( ) Pharmacy Records	

X_____(Initials) I DO ( ) or I DO NOT ( ) consent to the release of information relating to psychiatric or psychological testing or treatment, bio-feedback training, alcohol and/or drug abuse diagnosis, prognosis, and treatment, and/or HIV (AIDS) testing and/or results, or such disclosure shall be limited to the following specific types of information:

Purpose(s) for the release or disclosure of Protected Health Information ("PHI"): Litigation,

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I also understand that revocation will not apply to information that has already been released as specified by this authorization, or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

This consent shall become invalid 2 years from the date signed unless a different expiration date, event or condition is specified.

Specify: .

I understand the following:

1. Information disclosed by this authorization may be re-disclosed by the recipient of your PHI;
2. Such re-disclosure, as noted above, will no longer be protected by this authorization;
3. I have the right to receive a copy of this authorization;
4. A copy or facsimile (fax) of this authorization is as valid as the original;
5. I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. CFR § 164.508 (c) (2) (ii);
6. Revocation of this authorization must be done in writing to the health care entity noted herein; and
7. Information disclosed by this authorization may include records which indicate the presence of a communicable or non-communicable disease.

I hereby release _____from any and all legal liability and injuries that arise from the release of this PHI to the party named above.

I have read the above or have had it read to me and I authorize the disclosure of the PHI as stated.

In compliance with HIPAA [45 C.F.R. 164.512]