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

TO: _____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____
Street Address

_____
City, State and Zip Code

RE: Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

_____ All medical records, meaning every page in my record, including but not limited to: office notes, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical reports, clinic records, treatment plans, discharge summaries, correspondence, test results, and records received by other medical providers.

_____ All physical, occupational and rehab requests, consultations and progress notes.

_____ All cancer related records including pathology reports, metastases present, affected anatomic sites, as well as the presence of any cancer related syndromes, complications and treatment given.

_____ All pulmonary function testing including DLCO's and lung volumes, chest CXR and chest CT's.

_____ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, PET and bone scans.

_____ Other, specify:_____

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 abuse, I authorize the release or disclosure of this type of information.

This protected health information is disclosed for medical purposes.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following:

_____

_____

I understand the following: See 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 in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____

Signature of Patient or Legally Authorized Representative Date
(See 45CFR § 164 508(c)(1)(vi))

_____

Name and Relationship of Legally Authorized Representative to Patient

See 45CFR §164 508(c)(1)(iv))

_____

Witness Signature Date