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:	
record	w and evaluation in connection with	sure of all protected information for the purpose of a legal claim. I expressly request that the designated nder HIPAA identified above disclose full and complete the following:	
	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.		
	All physical, occupational and	rehab requests, consultations and progress notes.	
	All disability, Medicaid or Med of benefits.	licare records including claim forms and record of denial	
	All employment, personnel or wage records.		
	and specimens; radiology recor	gy, cytology, pathology, immunohistochemistry records ds and films including CT scan, MRI, MRA, EMG, onduction study, echocardiogram and cardiac CDs/films/reels and reports.	
	All pharmacy/prescription reco handouts/monographs.	All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.	
	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 a of this type of information.	abuse. I authorize the release or disclosure		
This protected health information is disclosed for the following purposes:			
This authorization is given in compliance with the fede alcohol or substance abuse records of 42 CFR 2.31, the specifically considered and expressly waived.			
You are authorized to release the above records to the the above-entitled matter who have agreed to pay reaso copies of such records:			
Name of Representative			
Representative Capacity (e.g. attorney, records request	tor, 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 wr information has been released in reliance uponb. The information released in response to this aut parties.c. My treatment or payment for my treatment can authorization.	this authorization. thorization may be re-disclosed to other		
Any facsimile, copy or photocopy of the authorization requested herein. This authorization shall be in force execution at which time this authorization expires.	-		
Signature of Patient or Legally Authorized Representa (See 45CFR § 164.508(c)(1)(vi))	tive Date		
Name and Relationship of Legally Authorized Represe (See 45CFR §164.508(c)(1)(iv))	entative to Patient		
Witness Signature	Date		