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:		
custo	I authorize and request the disclosure of all protected information for the purpose of reviewaluation in connection with a legal claim. I expressly request that the designated record odian of all covered entities under HIPAA identified above disclose full and complete proteical information including the following:		
1	All medical records, meaning every page in my record, including but not limited to: office face sheets, history and physical, consultation notes, inpatient, outpatient and emergency retreatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social work records, clinic records, treatment plans, admission records, discharge summaries, requests and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.	oom ker for	
	All physical, occupational and rehab requests, consultations and progress notes.		
	All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.	f	
	All employment, personnel or wage records. All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films inc CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogrand cardiac catheterization results, videos/CDs/films/reels and reports	luding	

Repr	resentative Capacity (e.g. attorney, records requestor, agent, etc.)			
Nam	e of Representative			
you 1	to supply copies of such records:			
	are authorized to release the above records to the following representatives ofin the above-entitled matter who have agreed to pay reasonable charges made by			
	or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.			
	authorization is given in compliance with the federal consent requirements for release of alcohol			
This	protected health information is disclosed for the following purposes:			
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.				
	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			
	If the health care provider has any questions about the scope of this disclosure, please contact the undersigned or my named representative as indicated herein before taking any action.			
	By checking this box, I acknowledge that the subject matter of this inquiry could cover areas of mental health care and other psychological or psychiatric medications, treatment, records and recordings of same. By checking this box I authorize the Health Care Provider identified above to release such records to the undersigned. All records are to be disclosed; any questions of inclusion must be resolved by disclosure, except for the following dates of service:			
	All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.			

Street Address				
City, S	tate and Zip Code			
a. b. c. Any farequest	rstand the following: See CFR §164.508(c)(2)(i-iii) I have a right to revoke this authorization in writing at a information has been released in reliance upon this authorization. The information released in response to this authorization My treatment or payment for my treatment cannot be cauthorization. csimile, copy or photocopy of the authorization shall authorization. This authorization shall be in force and effection at which time this authorization expires.	horization. Ion may be re-disclosed to other parties. Ion onditioned on the signing of this Ithorize you to release the records		
_	ure of Patient or Legally Authorized Representative CFR § 164.508(c)(1)(vi))	Date		
	and Relationship of Legally Authorized Representative CFR §164.508(c)(1)(iv))	to Patient		
Witnes	s Signature	Date		