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HIPAA AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

DATE:

TO:

This authorizes you to release to the office of the above attorney all treatment records and notes of whatever nature, all billing statements, and other information concerning:

PATIENT: **DOB:** **DOA:**

I understand that I may specify a date for the expiration of this authorization, but that it shall expire by law, without my express revocation, one year from the date written below. Revoking this authorization will not have any effect on actions that the health care provider took I reliance on the before the health care provider received notice of the revocation. The information to be disclosed may be protected y law. Information disclosed under this authorization may be redisclosed by the recipient and no longer protected by federal privacy regulations. I understand that my ability to receive care treatment from the health care provider will not be affected I do not sign this form. However, without my signature, this request to release the information describe above will not be honored. The protected health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases (including HIVAIDS) and/or genetic marker information. These records will be included in the information we will make available to the individual or organization I have identified above.

_____ DATE: _____

PATIENT SIGNATURE

If the patient is unable to authorize disclosure of this information, the reason is set forth below, and the supporting documentation is attached.

REASON:

*State basis for authority to give consent on patient's behalf: (a) Medical Care Power of Attorney, Guardianship, Court Order or Letter of Administration (copy attached); (b) Relative or person authorized by law (explain relationship or legal authority):

_____

_____

NOTE TO HEALTH CARE PROVIDERS: This authorization is provided in compliance with HIPPA. Failure to forward the requested information may render a health care provider liable for damages.

A PHOTOCOPY OF THIS AUTHORIZATION MAY BE USED IN LIEU OF THE ORIGINAL.