Rosenfeld Injury Lawyers

FIRM LETTERHEAD

Authorization to Use or Disclose Health Information Compliant with Health Insurance Portability and Accountability Act (HIPAA) Regulations.

Patient Name:
Date of Birth:
Social Security Number:

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual(s) or organization(s) are authorized to make the disclosure:_____
_____

3. The kind of information to be used or disclosed includes the following: complete medical records and itemized account statements.

4. The information identified above may be disclosed to the following individual(s) or organization(s):
_____
_____

5. The above-named individual(s) or organization(s) are permitted to use or disclose the above-identified information for the following purposes: litigation related to medical malpractice.

6. The above-named individual(s) or organization(s) are restricted from using or disclosing the information in the following way:
_____
_____

7. This authorization is valid until calendar date:_____

8. I understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider/ plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Regulations.

9. I understand that this authorization is voluntary and I may revoke it; however, the revocation must be in writing and must be sent/given to the facility record's department. I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

10. Refusal to sign this form will result in the following consequences: INFORMATION WILL NOT BE DISCLOSED/OBTAINED.

11. It is my full understanding that the records and communications to be disclosed WILL include sensitive information such as evaluation, habilitation/treatment information for mental health, developmental disabilities, alcohol or substance use/abuse or HIV/AIDs unless specifically checked below for exclusion.

12. _____
Signature of individual (Age 12 or older).

_____
Date/Time

13. _____
Signature of guardian (Under 18 or disabled).

_____
Date/Time

14. _____
Witness OR (2nd parent/guardian, if co-custodial, may sign here)

_____
Date/Time

15. _____
Signature of staff person disclosing/obtaining information

_____
Date/Time