HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HOSPITAL, MEDICAL, INSURANCE, AND PHARMACY RECORDS PURSUANT TO 45 CFR 164.508/GENERAL RECORDS RELEASE AUTHORIZATION

Name: _____

Date of Birth: _____

SSN: _____

Address: _____

_____

Telephone: _____

TO: [Name of Healthcare Provider, Physician, Facility]

_____

_____

_____

I, _____ hereby authorize the designated records custodian of the HIPAA covered* individual or entity identified above to disclose all protected health information for review and evaluation in connection with a legal claim. I expressly request that you disclose, make available, furnish with photocopies, and release to my attorney(s) at Jeeves Law Group, 954 1st Ave. N., St. Petersburg, Florida 33705:

A. All medical, psychological, psychiatric, and other written, photographic and radiographic information and documents relating in any way to my physical or mental condition spanning the time period of _____(date of birth) to the present, including but not limited to alcohol or drug treatment and AIDS/HIV status if applicable, in the possession of any and all doctors, physicians, therapists, psychologists, psychiatrists, counselors, pharmacists, pharmacies, hospitals, clinics, all other practitioners of any of the healing arts or sciences and all other organizations and institutions, public and private.

B. All academic, disciplinary, psychological and counseling records in the possession of any school, college, testing service, or other academic professional or institution.

C. All records of charges, payments and other financial matters relating to the aforementioned matters.

D. All records of employment, including personnel, payroll, counseling, testing, performance, assessment, medical, health insurance, and other records of any type that any employer or former employer may possess regarding me.

E. All governmental records concerning me, including but not limited to records of military services, the Veterans Administration, Social Security Administration, social welfare agencies, health care agencies, law enforcement agencies, National Crime Information Center, Internal Revenue Service, tax and revenue agencies of any state government wherever located, and any and all other governmental agencies.

This protected health information is disclosed for the following purposes: At the request of the undersigned individual.

I acknowledge that ***I have the right to revoke this authorization***, in writing, by sending written notification to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and to no longer be protected under 45 CFR 164.508.

I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect and amend my medical records as provided in 45 CFR 164.526. I have the right to an accounting of the use and disclosure of my health information to any third party as provided in 45 CFR 164.528.

This will further authorize you to provide updated medical records for the undersigned to my above referenced attorney(s) at Jeeves Law Group through the expiration date for this authorization without additional authorization. A facsimile, copy or photocopy of this authorization shall authorize you to release the records herein. ***This authorization shall be in force and effect until four years from the date of execution at which time this authorization expires.***

* **If you are an individual or entity that is not subject to HIPAA regulations, please disregard the language included pursuant to 45 CFR 164.508 and consider this a general records release authorization.**

* **My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.**

Dated this _____ day of _____, 200__.

_____
Signature of Plaintiff/Patient or Personal Representative

_____
Print or Type Name of Plaintiff/Patient or Personal Representative

_____
Description of Personal Representative's Authority to Sign for Plaintiff/Patient (attach documents which show authority)

FOR THE PARENT OR GUARDIAN

I hereby certify that I am the parent/guardian of the minor/ward named

_____.

_____ _____

Dated Signed