AUTHORIZATION TO RELEASE RECORDS

COMPLETION OF THIS DOCUMENT AUTHORIZES RECORDS TO BE RELEASED.

I hereby authorize _____ to release records
(Entity authorized to release records)

to: _____

(Discovery Agent for: _____)

Release Records as follows:

Name:_____ AKA: _____

SSN/MRN:_____ DOB: _____

INFORMATION TO BE DISCLOSED: *Nothing shall be removed, deleted, altered or withheld.*

- ☐ Medical Records (date range):_____
- ☐ Billing Records (date range):_____
- ☐ OTHER:_____

***Include the release of the sensitive information if signed**. (Full Signature Required.)

☐ Mental Health: Signature:_____ Date:_____

☐ Alcohol/Drug: Signature:_____ Date:_____

☐ HIV/AIDS: Signature:_____ Date:_____

PURPOSE: I understand that the information requested will be used to assist my attorney to discover the liability, nature and extent of a claim for injuries and disabilities, to establish benefits, expenses and damages. *Treatment, payment , enrollment or eligibility for benefits will not be conditioned on my providing/refusing to complete this authorization.*

EXPIRATION: I understand that this authorization shall remain valid for 1 year after the date of my signature unless a date is specified here:_____.

RIGHT TO REVOKE: I understand that I can revoke this authorization in writing prior to the release of information from the disclosing party. Revocation must be made in writing, signed by me or on my behalf and delivered to the entity authorized to release records.

REDISCLOSURE: I understand that above described entity, may not lawfully disclose the information unless disclosure is specifically required or permitted by law. I understand the risk and possibility of unauthorized disclosure by the recipient and that the information may no longer be protected by the federal confidentiality law (HIPAA).

A copy of this Authorization is valid as the original. A copy of this signed authorization is for me to keep.

_____ _____ _____

Date Signature If not patient, print your name & relationship