AUTHORIAZATION FOR RELEASE OF MEDICAL RECORDS PURSUANT TO 45 CFR 164.508 & 164.512(HIPAA)

OUR FILE NO.: **DATE:** _____

To: _____
_____
_____
_____
_____
_____
Name of Provider/Facility

FILM REQUESTED:_____

Patient Name: _____
Address: _____
DOB: _____
SS#: _____

I, _____, authorize you to disclose and release the following protected health information for the **WRITTEN MEDICAL RECORDS:** any and all medical records, all impatient and outpatient charts and records, hospital charts and records, doctor and nurse notes, emergency room records, correspondence, memoranda, physical therapy and rehabilitation records, patient questionnaire forms, patient history forms, social service records, laboratory reports, diagnostic reports. **RADIOLOGY:** any and all x-rays, MRI films, CAT scans, in all forms including original films, copy of computer storage of the data on disk or tape and a copy of the reports. **PRESCRIPTION RECORDS:** any and all prescription records, the issuance of sale of prescription drugs, original doctor's prescription forms, refill records and pharmacy records. **PROTOCOL:** any and all documents describing the protocol and criteria for administration and interpretation of diagnostic tests and imaging. **BILLING:** any and all billing records, including itemized statements of charges, payments, all insurance records, including all claims, claim forms, correspondence, payments and reports.

Also, please disclose and release the following protected health care information: (only if checked below):

(check) □ Drug and Alcohol Records SIGNATURE: _____
□ HIV and AIDS Records SIGNATURE: _____
□ Mental Health Records SIGNATURE: _____

This protected health information is disclosed for the following purposes: Litigation

You are authorized to release the above records to the following representatives of _____ who have agreed to pay reasonable charges made by you to supply copies of such records:

David K. Lucas and Associates
Name of Representative(s)
Legal Counsel
Representative capacity (e.g. attorney, records requestor, agent, etc.)
140 South Main Street, Suite 301
Street address
Greensburg, Pa 15601 724-836-6585
City, State and Zip Code **Fax No.**

This authorization shall be in force and effect until conclusion of litigation for which these records are sought. I have the right to revoke this authorization, in writing, by sending written notification to you. I understand that my decision to revoke the authorization may result in sanctions being imposed by the court for failure to comply with discovery requests. I further understand that a revocation is not effective to the extent that you have relied on my authorization to disclose protected health information. In addition, I understand that the information may be disclosed and no longer subject to protection. I understand that I have the right to:

- Inspect or copy the individually identifiable health information to be disclosed.
- Refuse to sign this authorization.
- That I am entitled to a copy of this completed authorization form.

This form also constitutes authority for you to produce and make photostatic copies of all such records, and to forward the same by mail to the above mentioned law office. A photostatic copy of this Authorization shall have the same effect as the original.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

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