AUTHORIZATION FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (MEDICAL RECORDS) PURSUANT TO HIPAA

To: **(Health care Provider)**

Re **Patient's Name:**_____ **Date of Birth:** _____

Patient's Address: _____

Social Security No.: _____

I. **RECORDS/INFORMATION TO BE DISCLOSED:** This authorization applies to any and all of the records or documents in your control or possession, whether or not created by you, including but not limited to the types of records listed below and including but not limited to all electronically generated or stored records:

A. All records, reports, test results of other documents concerning the medical care, treatment, and examination of the aforementioned patient;

B. All pathology that is not necessary for care and treatment, original tissue blocks, original tissue slides, wet tissue, records, self histories, histochemical and immunochemical reports, autopsy reports, including but not limited to hand-written notes and/or drawings associated with the autopsy, test results, other documents, or electronic information concerning the medical care, treatment, and examination of the aforementioned person, including any photomicrographs, Millipore filters, written tissue digestion protocol or other material related in any way to any lung tissue asbestos fiber burden analysis or ferruginous body study performed on the tissues of the aforementioned patient;

C Copies of all correspondence concerning the medical care, treatment, examination, or physical condition of the aforementioned patient

D Copies of bills or statements of services rendered for such service;

E X-ray films, MRI films, CT films and all other imaging films involving the aforementioned patient.

II. **PERSONS, FACILITY, ORGANIZATION, OR CLASS OF PERSONS AUTHORIZED TO DISCLOSE RECORDS/INFORMATION:** The following persons or organizations are authorized to make the requested use or disclosure of my above-identified protected health information:

_____

III. **PERSONS, FACILITY, ORGANIZATION AUTHORIZED TO RECEIVE THE RECORDS/INFORMATION:** The following persons or organizations are authorized to receive my above identified protected health information: _____, **or its representative(s).**

IV. **PURPOSE FOR AUTHORIZATION** - This authorized use or disclosure is for the following specific purpose(s): at the request of the individual Patient/or Patient's Representative for **Use in civil litigation in a civil action brought by Plaintiff(s).**

V. EXPIRATION OF AUTHORIZATION - This authorization will expire upon the following event: **Final resolution of the above-identified civil action.**

VI. AUTHORIZING SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE:
I authorize the use or disclosure of the records/information described below and:

- I am not required to sign this authorization and may in fact refuse to sign this authorization.
- I understand that the authorized health care provider will not condition my treatment or payment for my treatment on my signing this authorization.
- I understand that if the person or entity that receives the described records/information is not subject to federal privacy regulations or other laws, the records/information may be re-disclosed and no longer protected by those regulations
- I also understand that certain records may be protected by federal or state law, including HIV, psychiatric or mental health treatment, alcohol/drug treatment or communicable diseases, and I am requesting that any and all such protected records be released under this authorization.
- I know that I may inspect or copy the protected health information sought to be used or disclosed in this authorization as permitted by the federal privacy regulations.
- I know that I have the right to revoke this authorization at any time. My revocation must be in writing and must bear my signature. My revocation must be submitted to the authorized health care provider disclosed above.
- I understand that if I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on this authorization.
- I have discussed this authorization with my attorney and he has advised me of my rights pursuant to HIPAA.
- **This authorization does <u>not</u> waive my doctor/patient privilege.**

Copies of the above-referenced materials should be numbered. A photostatic copy of this Authorization shall be considered as effective and valid as the original.

THIS AUTHORIZATION DOES <u>NOT</u> AUTHORIZE DISCUSSION OF THE MEDICAL CARE AND/OR CONDITION OF THE ABOVE PARTY. This Authorization is for securing copies of the medical records, X-Rays films, CT films, MRI films, bills, pathology, and office notes only as described herein. This does not authorize the securing of a narrative medical report, nor does it authorize the bearer to conduct ex-parte interviews with any medical personnel regarding the treatments and conditions.

I certify that I have read, signed, and received a copy of this authorization.

_____ _____
Signature of Patient (or Patient's Representative) **Date of Signature**

_____
Patient Representative's Relationship/Capacity to Patient

_____
Printed name of Personal Representative

_____
Address and Telephone number of Personal Representative