

# PATIENT'S RELEASE OF HEALTH CARE INFORMATION

Patient's Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby instruct my providers to provide full and complete information to \_\_\_\_\_ and to accept this authorization form and release the protected information requested without requiring any additional authorizations. I specifically waive any "minimally necessary" limitations of HIPAA.

Health Care Provider/Facility \_\_\_\_\_

is hereby authorized to release health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, employees, and designated agents of my attorneys, to wit:

Attorney's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

This request and authorization applies to:

\_\_\_ Health care information relating to the following treatment, condition, or dates of treatment: \_\_\_\_\_

\_\_\_ All health care information:

\_\_\_ Other: \_\_\_\_\_

**How the Information will be used:** Said information shall be used for any and all purposes for \_\_\_\_\_ to pursue payment of care expenses and in providing legal services to me in conjunction with my case. Following said disclosure the information may no longer be subject to HIPAA protection, as it may be subject to re-disclosure that is unprotected absent specific laws protecting specific sensitive information.

**Revocation of Prior Authorization:** All medical authorizations by the patient or patient's authorized representatives given before the date of this release for any reason whatsoever are hereby revoked.

**Unlawful Disclosure Prohibited:** State and Federal prohibits any healthcare provider from releasing any healthcare information about a patient to another person without the consent of the patient. You are requested to disclose no such information to any insurance adjuster or any other person without written authority from me which is printed on the letterhead of my attorney.

**Effect of Photocopy:** A photocopy of this release shall have the same force and effect as a signed original.

**Authorization expires 90 days from date of signature.** Thereafter, no authorization exists unless an updated release is provided by: \_\_\_\_\_

I understand that I have the right to revoke this release for any information not yet provided to \_\_\_\_\_ by providing notice of revocation in writing to the above named care provider. I also understand that I have the right to refuse to authorize disclosure at all.

\_\_\_\_\_  
Signature of Patient or Patient's Authorized Representative

\_\_\_\_\_  
Date