HIPAA Release and Authorization

I, the undersigned, authorize any doctor, physician, medical specialist, psychiatrist, chiropractor, health-care professional, dentist, optometrist, health plan, hospital, hospice, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, pathologist, or other provider of medical or mental health care, as well as any insurance company (referred to herein as a "covered entity"), to give, disclose or release to:

_____
Name of Representative

_____
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____
Street Address, City, State and Zip Code

or, if the person designated above is unavailable, to:

_____
Name of Representative

_____
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____
Street Address, City, State and Zip Code

all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including but not limited to:

(a) All office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

(b) All physical, occupational and rehab requests, consultations and progress notes.

(c) All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

(d) All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

(e) All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

(f) All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits.

This Release and Authorization applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 1320d and 45 CFR 160-164 (as it may be amended from time to time). This Release and Authorization authorizes the person(s) designated above to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information, even if, at the time, I am fully competent to ask questions and discuss this matter. Furthermore, the information released in response to this Release and Authorization may be re-disclosed to other parties.

This Release and Authorization shall be effective on the date below, and shall continue until revoked by me, in writing. Copies or facsimiles of this Release and Authorization shall be as valid as the original Release and Authorization.

_____
Signature

_____
Printed Name

_____
Mailing Street Address

_____
City, State, Zip

_____
Phone

_____
E-Mail Address

_____
Date of Birth

_____
Witness Signature
(cannot be a person designated above)

_____
Printed Name of Witness

_____
Date