

**HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT
INFORMATION PURSUANT TO 45 CFR 164.508**

TO: _____ Name of Healthcare
Provider/Physician/Facility/Medicare Contractor

_____ Street Address

_____ City, State and Zip Code

RE: _____
Patient Name

Date of Birth: _____ Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation of my health care claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above release to me all protected medical information including the following:

_____ Medical records, meaning every page in my record, including but not limited to: office notes, face sheets, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, physicals, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and responses to documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, video and records received by other medical providers.

_____ All physical, occupational and rehab requests, consultations and progress notes.

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

_____ All employment, personnel or wage records.

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

_____ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

_____ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to me or payment or denial of benefits for the period _____ to _____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes:

This authorization is given in compliance with the federal consent requirements for release of alcohol or records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to my Attorney's office listed below who have agreed to made by you to supply copies of such records:

Brent Jex, Esq.
Name of Representative

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

6255 Lusk Boulevard, Suite 140
Street Address

San Diego, CA 92121
City, State and Zip Code

I understand the following: See CFR §164.508(c)(2)(i-iii)

- a. I have a right to revoke this authorization in writing at any time, except to the extent information I rely upon this authorization.
- b. The information released in response to this authorization may be re-disclosed to other parties by
- c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein force and effect until two years from date of execution at which time this authorization expires.

Date _____
Signature of Patient (See 45CFR § 164.508(c)(1)(vi))

Date _____
Witness

Name and Relationship of Legally Authorized Representative to Patient (See 45CFR §164.508(c)(1)(iv))