AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

To:

Patient Printed Name: Date of Birth:
Address:

Social Security No.: Telephone:

Covering the Periods of Health Care from to

Please check type of information authorized to be released:

ANY Part of Medical Record or Entire Medical Record (**see attached request**)	X	Complete Detailed Pharmacy Record		Discharge Summary	
		Consultation Reports		Pathology Records/Reports	
History and Physical Exam		Operative Reports		Radiology Images/Reports	
Laboratory Test Results/Reports		Itemized Bill		Implant Logs/Sticker Pages	

Other:

Purpose of Request: Civil Litigation

I authorize disclosure of my personal healthcare information to: The Nations Law Firm, 9703 Richmond Ave., Suite 200, Houston, TX 77042

Release of Sensitive Information: I understand that the information to be released may contain references to sensitive information related to mental and behavioral health services, genetic testing, HIV/AIDS or other communicable diseases, reproductive rights, sexual and reproductive health, substance use disorder, and sickle cell anemia, and I agree to its release. **Initials**

Attestation for Disclosure of Information Potentially Related to Reproductive Healthcare: I attest that the use or disclosure of protected health information that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) because the purpose of the use or disclosure of protected health information is not to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes. I understand that I may be subject to criminal penalties pursuant to 42 U.S.C. 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person. **Initials**

Time Limit and Right to Revoke Authorization: Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at the above-named facility.

Re-disclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

IT IS MY EXPRESS INTENTION THAT THIS AUTHORIZATION IS GIVEN IN COMPLIANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) (PUBLIC LAW 104-191).

Signature of Patient or Personal Representative Who May Request Disclosure: I am voluntarily signing this authorization. I understand that I may refuse to sign this authorization, and I understand that the above-described facility may not condition my treatment, payment for services or eligibility for benefits or enrollment on whether I sign this authorization form. I can inspect or copy the protected health information to be used or disclosed. I authorize the above-named facility to use and disclose the protected health information described above. I further authorize The Nations Law Firm and any healthcare provider to whom a request is directed to use a photocopy of this authorization as an original. I understand that I have a right to receive a copy of this authorization after signing it.

Signature:_____ Date: _____

Authority to Sign if Not Patient: _____