AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) UNDER HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

1. The undersigned patient, named below, hereby executes this authorization in compliance with the Federal Health Insurance Portability and Accountability Act, HIPAA, 45 CFR 164.104.

2. This authorization is directed to the following healthcare service provider (including its agents, employees and associates):

____

____

____

____

3. The above-named healthcare service provider is requested to release the protected health information (PHI) that is described below, to the patient's attorney:

Law Offices of Bruce H. Carraway, III

501 Pulliam St. SW, Suite 519 Fax 470-300-8018
Atlanta, GA 30312
email ruth@forinjuredworker.com

4. The protected health information released herein is specifically as follows:

All medical information of any nature whatsoever, from any source whatsoever, which is maintained by you in your records regarding the referenced patient and which is requested by my attorneys. If you are a physician or out-patient clinic, you are authorized to send your entire chart upon their request, including not only the records dictated or written up by you, but also insurance records, handwritten notes, telephone memoranda, outside records, correspondence, or any other tangible item maintained in my chart.

If you are a hospital, you are authorized to release my complete records including x-rays or similar studies. office notes, face sheets, discharge summaries, history and physical, consultation notes, intra-operative records, anesthesia records, operative reports, recovery room, pathology reports, medication administration records, EKG reports, EKG strips, EEG reports, EEG strips, therapy notes, orders, progress notes, laboratory results, nurses notes, vital sign sheets, intake/output records, reports of all x-rays, mammograms, CT scans, MRIs or PET scans, emergency room records, transfer records, operative reports, anesthesia records, admitting summary, discharge summary, discharge instructions, personal property list, in-patient records, out-patient records, clinic records, correspondence, photographs, videotapes, telephone messages, computer generated information, medical bills, pharmacy and drug records, health insurance forms, insurance claim forms, insurance payment forms, Medicaid or Medicare records, concerning any medical treatment that I have received from you, at your institution, or which you keep in the regular course of business. I hereby authorize release of all records regarding mental health, psychiatric, chemical dependency or HIV. A photo static copy of this authorization shall be as valid as the original.

Note: a Copy of this Authorization Shall Be Treated as an Original

The records include, but are not limited to, the following items:

____ Most Recent History and Physical ____ All From ______ to ______
____ Most Recent Discharge Summary ____ All From ______ to ______
____ Initial Patient Paperwork/Questionnaires ____ All From ______ to

____ Office Notes and Reports ____ All From ______ to ______
____ Physical Therapy Records and Notes ____ All From ______ to ______
____ Laboratory Reports and Results ____ All
____ X-ray and Imaging Reports ____ All
____ Consultation Reports from any other Physicians ____ All
____ Entire Record and/or Chart
____ Final Narrative Reports & Impairment Ratings
____ Itemized Bill for Services Rendered ____ Total Charges ____ Balance
____ Medicare/Medicaid, ERISA, group health, medical, worker's compensation, etc., insurance and or collateral source benefits providers' records (i.e., medical records, medical reports, insurance and submission claim forms, payout records, benefits and policy information, subrogation language, claims of lien, etc.)
____ Other ______________________________

REQUIRED DISCLOSURES - 45 CFR 164.508(c)

A. This protected health information is to be used for the following purpose: A civil legal claim or proceeding.

B. This authorization may be revoked by a signed and properly dated written revocation, delivered to the healthcare provider named above, provided that this release cannot be revoked as to protected health information that had been previously released in reliance on this document.

C. The undersigned acknowledges that a refusal to sign this form will not result in a denial of healthcare by the hospital or any other healthcare provider and that this release has not been coerced by a healthcare entity or any of its business associates.

D. The undersigned acknowledges that once the PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, insurance companies, and even may become public record if filed with a court of law.

E. This authorization will be effective for the entire duration of the legal matters related to the accident which involved the patient and occurred on ______________________ (month/day/year), unless earlier revoked in writing.

____
Patient's Signature

____
Signature of Authorized Representative (Parent, Legal Guardian or Personal Representative)

____
Patient's Name

____
Witness

____
Patient's Date of Birth

____
Dated

____
Patient's Social Security Number

Note: a Copy of this Authorization Shall Be Treated as an Original