Authorization to Disclose Protected Health Information

Provider: _____

Address: _____

Patient: _____

Date of Birth: _____ SSN: _____

I am a patient of your practice and hereby authorize the use or disclosure of my protected health information to the following individual/organization in relationship to my pending personal injury claim:

Attorney: _____ Law Firm: *Levinson Axelrod, P.A.*

□	2 Lincoln Highway, P.O. Box 2905, Edison, NJ 08840	732-494-2727
□	274 Church Street, Belford, NJ 07718	732-787-3200
□	124 Route 31, Flemington, NJ 08822	908-782-6766
□	654 Lacey Road, Forked River, NJ 08731	609-971-1177
□	302 Route 206, Hillsborough, NJ 08844	908-359-0110
□	3641 Route 9 North, Howell, NJ 07731	732-730-9600
□	220 Forsgate Drive, Jamesburg, NJ 08831	732-656-3650

Please provide my entire certified medical record with any and all radiological films, itemized bills (with CPT codes), Health Insurance Claim Forms (CMS-1500) and any correspondences with insurance carriers.

I understand and agree to the following:

- *Revocation:* I have the right to revoke this authorization at any time.
- *Procedure for Revocation:* Any revocation must be in writing and will not apply to information that has already been released in response to this authorization.
- *Duration:* Unless otherwise revoked, this authorization will expire upon the resolution of my personal injury or insurance benefits claim.
- *Inspection*: I may inspect or copy the information to be used or disclosed, pursuant to 45 *C.F.R.* 164.524.
- *Re-Disclosure*: Any disclosure of information carries with it the potential for an unauthorized re-disclosure, which may or may not be protected by federal or state privacy laws.
- *STDs/Psychological/Dependency/Abuse*: Information contained in my health records may include details or treatment related to the following: sexually transmitted diseases (including AIDS/HIV); mental health; behavioral health; alcohol dependency/abuse; drug dependency/abuse and/or physical/mental abuse.
- *Voluntariness:* This authorization is being given voluntarily and I have the right to refuse signing the same.

Patient's Signature: _____ Date: _____

Note to Provider: In accordance with N.J.A.C. 13:35-6.5, the records must be provided within 30 days from receipt of this request. You may charge a fee for the reproduction of records, which shall be no greater than $1.00 per page or $100.00 for the entire record, whichever is less. If the record requested is less than 10 pages, you may charge up to $10.00 to cover postage and the miscellaneous costs associated with retrieval of the record. If you wish to transmit the records electronically via fax or PDF, please contact our office in advance to arrange for the same.