Authorization to Disclose Protected Health Information

Provider: _____

Address:_____

Patient:_____

Date of Birth: _____ SSN: _____

I have been 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:

Defense Law Firm:_____

Please provide the above defense counsel with certified copies of my medical records.

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 one (1) year from the date of the initial authorization.
- *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: _____