AUTHORIZATION FOR MEDICAL INFORMATION

I hereby authorize use or disclosure of protected health information about me as described below:

1. The following specific person or class of persons or facility is authorized to make the requested use or disclosure:

_____

_____

2. The following persons or class of persons may receive disclosure of protected health information for use or disclosure: _____

3. The specific information that should be disclosed is: **Full and complete medical records,** including, but not limited to hospital records, diagnostic films, test results (CT Scan, EEG, EKG, MRI, NCS, X-Ray, etc.), physician's notes, nurse's notes physician assistant's notes, opinions, psychological and psychiatric reports, and any other information hereby requested, to _____, or to any representative, attorney or investigator from the law office of _____.

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of the person or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this Authorization by notifying Attorney _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this Authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this Authorization is furnished may not condition its treatment of me based on whether or not I sign this Authorization.

6. This Authorization expires on _____, OR upon occurrence of the purpose of the intended use or disclosure of information about me.

PATIENTS NAME: _____
DATE OF BIRTH: _____
SOCIAL SECURITY NUMBER: _____

This _____ day of _____, 20 _____

SIGNATURE OF PATIENT _____