HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

TO: ____
Name of Healthcare Provider/Physician/Facility/Medicare or Medicaid Contractor

RE: Patient Name: ____ Date of Injury: _____________

Date of Birth: ____ SSN: XXX-XX-____________

I authorize and request the disclosure of all protected information for the purpose of resolving a legal claim pursuant to the Health Insurance Portability and Accountability Act Privacy Regulations (HIPPA), 45 CFR § 164.508. I expressly request the designated record custodian of the above medical entity or provider to disclose full and complete protected medical information including **medical records, physician's notes, lab reports, and itemized billing statements for dates of service: ____________________** _ to present.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. It may also include behavioral and mental health service information. I authorize the release or disclosure of this type of information.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

I understand I have the right to revoke this authorization in writing at any time. A revocation does not apply to information already released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **This authorization shall be effective for two years from the date of execution, unless otherwise revoked.** 45 CFR § 164.508

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand the information released may be re-disclosed to other unauthorized parties and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I may contact the medical provider above wherefrom said information is being requested.

You are authorized to release the above records to the Law Firm of Shawndria McCoy, PLLC.
Please forward all documents to: 4030 Wake Forest Road, Suite 300; Raleigh, NC 27609.

____ ________________________
Patient (or Personal Representative's) Signature Date

____ ________________________
Witness/Parent Date