HIPAA

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

MEDICAL RECORDS

THIS DOCUMENT DOES NOT AUTHORIZE RELEASE OF ANY RECORDS CONCERNING
OR RELATED TO ANY ALCOHOL, DRUG, HIV OR PSYCHIATRIC CARE, TESTING OR TREATMENT

Patient name: _____ D.O.B.: ___/___/___ S.S.N.: _____

Dates of Treatment: beginning _____ through _____

[relevant time period must be inserted]

AUTHORIZATION:

I, _____, authorize the disclosure of my protected health information as described herein.

1. I authorize the following person(s) and/or organization(s) to disclose the protected health information described in paragraph 3.

[individual medical provider name must be inserted]

2. I authorize the following person(s) and/or organization(s) to receive the protected health information described in paragraph 3.

[individual firm or lawyer must be inserted]

3. The records authorized to be released include:

all medical records and billing records including without limitation: medical reports, clinical notes, nurse's notes, history of injury, subjective and objective complaints, x-rays, x-ray reports or interpretations, otherdiagnostic tests (including a copy of the report), diagnosis and prognosis; if applicable, emergency room records or logs, history and physical examination report, laboratory reports, tissue committee

reports, reports of operation, operation logs, progress notes, doctors' orders, nurse's notes, physical therapy records, admission and discharge summaries, and all out-patient records; hospital bills, bills for the services you have rendered, bills for medication; and any other documents, records, or information in your possession relative to my past, present or future physical condition.

4. I expressly waive any laws, regulations and rules of ethics which might prevent any health care provider who has examined or treated me from disclosing my records pursuant to this Authorization.

5. The purpose of this Authorization relates to a legal action now pending in the United States District Court for the District of New Mexico.

6. I understand that I may revoke this Authorization at any time by sending a letter to the person or organization listed in paragraph one (1), except to the extent that such person(s) and/or organization(s) may have already taken action in reliance on this Authorization. If I do not sign, or if I later revoke, this Authorization, the services provided to me by such person or organization will not be affected in any way.

7. This Authorization expires one year from its date of execution.

8. THIS AUTHORIZATION DOES NOT PERMIT THE PERSON OR ORGANIZATION LISTED IN PARAGRAPH TWO (2) TO OBTAIN OR REQUEST FROM THE MEDICAL PROVIDER IDENTIFIED IN PARAGRAPH ONE (1) ORAL STATEMENTS, OPINIONS, INTERVIEWS, OR REPORTS THAT ARE NOT ALREADY IN EXISTENCE.

9. Copying costs will be borne by the person or organization named in paragraph two (2).

10. A photocopy or facsimile of this Authorization is as valid as an original.

11. I understand that a potential exists for information that is disclosed pursuant to this Authorization to be subject to re-disclosure by the recipient and therefore be no longer protected by federal confidentiality rules.

SIGNATURE OF PATIENT OR
AUTHORIZED REPRESENTATIVE: _____

CAPACITY OF REPRESENTATIVE,
IF APPLICABLE: _____

DATE OF SIGNATURE: _____