PATIENT AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
(HIPAA Compliant)

I, _____, residing at:_____ give permission to release my health information and hereby authorize _____, its agents, employees and associates, to release the protected health information described below to my attorney, his agents and employees:

JAY ROTHLEIN, ESQ.
407 Lincoln Road, Suite 2-A
Miami Beach, FL 33139
Tel: (305)532-2250
Fax: (305)534-8813

_____ Entire Records/File including but not limited to facility/office/clinic/home care/and behavioral health medical records, including but not limited to medical history, reports, charts, notes, labs, x-rays, MRI's, special tests, consultation reports, operative reports, physical exams, progress notes, therapy notes, medication lists, emergency room records, physician orders, discharge summary, clinical exams and itemized patient billing statements.

_____ any and all medical records which may contain information regarding the diagnosis or sensitive treatment of behavioral health, mental illness, psychiatric treatment, drug and/or alcohol abuse, HIV/AIDS and/or sexually transmitted diseases.

_____ any and all patient billing statement(s), to and including ITEMIZED BILLING information which summarizes total charges for services rendered, to and including all payments received from any and all parties and/or insurance company(ies);

_____ any and all patient LEDGER(s) which reflects contractual adjustments, balances (balance ledger), financial transaction listing and payments (payment ledger);

_____ other specific information as follows:_____
and specific dates of service from _____ to_____

The protected health information is to be used for the following Legal purpose:

DATE OF ACCIDENT/INCIDENT or OTHER: _____
TIME PERIOD REQUESTED/TREATMENT DATES: _____

I further authorize the above entity/provider to discuss these records, photos or any other information with my above referenced attorney, his agents, employees and associates, should further information be requested. **The entity/provider may accept a photocopy of this HIPAA as valid.**

This release may be revoked by a signed and properly dated written revocation, delivered to the medical provider or its copy service, *provided* that this release cannot be revoked as to protected health information that had been previously release in reliance on this document.

I understand that a refusal to sign this form will not result in a denial of health care by the hospital or any other health care provider and that this release had not been coerced by a health care entity or any of its business associates.

I understand that once the PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, insurance companies and even may become public record if filed with a court of law.

This Medical Authorization shall expire upon final resolution of my pending claim/case as stated above.

Dated this ____ day of _____, 201__.

_____
Signature of Patient

_____
Print Name of Patient

Date of Birth:_____

Last 4 numbers SSN:_____