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
(305)532-2250 (Phone); (305)534-8813 (Fax)

_____ 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.

_____ 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:

SOCIAL SECURITY DISABILITY CLAIM
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 _____, 20____.

_____
Signature of Patient

_____
Print Name of Patient

Date of Birth:_____

Last 4 numbers SSN:_____