Authorization for Release of Medical Information

Compliant with HIPAA Privacy Rule revised 4/3/03

1. By signing this authorization, I hereby authorize _____ to use or disclose certain medical information as set forth below pertaining to the following patient:
   _____

2. I authorize the release of all Protected Health Information (PHI) as defined in 45 CFR §§ 160 and 164, specifically including any psychotherapy notes, as well as any non-protected information.

3. I authorize this information to be disclosed to the attorney with the following name and address:
   Lloyd E. Solt, Esq.
   Lloyd E. Solt, P.A.
   1500 Colonial Blvd., Suite 234
   Fort Myers, FL 33907

4. I authorize this information to be disclosed to the attorney named above for the purpose of assistance with legal matters.

5. I understand that I have the right to revoke this Authorization at any time in writing, except to the extent that _____ has already acted in reliance on the Authorization. I can revoke this Authorization by providing a written revocation to _____ at the following address:
   _____
   _____
   _____
   Attention: Privacy Officer

6. I understand that _____ may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

7. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may therefore no longer be subject to applicable privacy laws.

8. This Authorization shall be effective for the entire duration of the legal matters related to the accident which involved the patient and which occurred on _____ or for five (5) years, whichever occurs first, unless revoked in writing.

Authorization from Patient

_____
Signature of Patient

_____
Printed Name of Patient

_____
Date

Authorization from Person other than Patient

_____
Signature of Person other than Patient

_____
Printed Name of Person other than Patient

_____
Legal Relationship to Patient (attach documentation)

_____
Date

_____
Street Address / P.O. Box of Person making Authorization

_____
City/State/Zip Code of Person making Authorization

_____
Telephone Number of Person making Authorization