THE DAVIS LAW FIRM

HIPAA AUTHORIZATION FOR MEDICAL RECORDS

PATIENT'S FULL NAME: _____DOB: _____SSN (last 4 digits): _____

I hereby authorize (Name of provider) _____

to release all existing medical records and information from: _____ to the present

regarding the above referenced patient's medical/mental health care, treatment, physical, medical, mental condition revealed by your observation or treatment of past, present and future to:

The Davis Law Firm, P.C., Terence Davis, whose address is 201 S. Lakeline Blvd., Suite 202, Cedar Park, Texas 78613 (512) 244-3302 and Fax No. is (512) 271-5532**.**
team@cedarparkattorney.com

The purpose of this authorization is in connection with litigation. I understand that this authorization includes information regarding the diagnosis and treatment.

I, the undersigned individual, am on notice that:

(1) Initiating this request for disclosure of protected health information, and any disclosure of the same pursuant hereto is at the request of the individual.

(2) Any health care provider disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

(3) This authorization can be revoked through written notice to the individuals listed above.

The undersigned is aware of the potential that protected health information disclosed pursuant to this authorization is subject to re-disclosure in a manner that will not be protected by HIPAA regulations.

(4) A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until a final disposition of the case styled or (1) year from the date of this authorization, whichever comes later.

Date: _____ Patient Signature _____

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.