HIPPA AUTHORIZATION FORM
45 CRF SUBSTITLE A. SUCHAPTER C.
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO:
RE:

You are **HEREBY AUTHORIZED** to release any and all of my protected health information to my attorneys, LAW OFFICE OF RUBEN M. RUIZ, or their agents, pursuant to Tile 45, California Code of Regulations, Section 160.103, et seq. (HIPPA) California Civil Code Section 56, et. seq. and California Evidence Code, Section 1158, for their use, investigation, evaluation, and handling of my legal matter:

a) All medical bills, billing statements, insurance records and billing records, and
b) Any and all medical records, and any of the information pertaining to this patient.
c) Any and all insurance, medical insurance records/information and/or the alike.

I UNDERSTAND that any information obtained will not be released by RUBEN M. RUIZ, or their legal representatives to any person or organization which does not have an interest in the investigation, evaluation, or other handling or my specific claim, or as may otherwise be lawfully required, or as I may further authorize.

VALIDITY AND REVOCATION: **45 CFR 164.508(c)(2)(i).** **I AGREE** that this authorization shall be valid for a period of five (5) years form the date shown below unless I revoke it prior, which I understand must be done in writing, and submitted the LAW OFFICES OF RUBEN M. RUIZ.

REDISCLOSURE STATEMENT: 45 CFR 164.508(c)(2)(i). I understand that there is the potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected.

NO EFFECT TO CARE OR BENEFITS: 45 CFR 164.508(c)(2)(ii). The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, by stating either:
(A) The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations in paragraph (b)(4) of this section applies; or
(B) The consequences to the individual of a refusal to sign the authorization when, in accordance with paragraph (b)(4) of this section, the covered entity can condition treatment, enrollment in the health plan, or eligibility for benefits on failure to obtain such authorization.

I AGREE that a photographic of this authorization shall be as valid as the original.

I UNDERSTAND that the authorized information includes, but is not limited to, matters pertaining to the accident or injury which

YOU HAVE READ AND UNDERSTAND ALL OF THE PROVISIONS INCLUDED HEREIN.

Name:_____ Date of Birth: _____

By: _____ Date: _____
Claimant/Guardian/Attorney-in-Fact