HIPAA COMPLIANT MEDICAL AUTHORIZATION

To: Regarding:

I hereby authorize, for personal reasons, the release of all medical, hospital, pharmaceutical and psychiatric records which shall include, without limitation:

1. All medical records in your possession, including but not limited to: physical therapy, rehabilitation, vocational rehabilitation, narrative reports, operative reports, nurses notes, health questionnaires, diagnostic tests and reports, office notes, telephone messages, psychotherapy records, pharmacy records, hospital records and itemized billing statements.
2. This includes records generated by other health care providers which are continued in my chart.
3. This includes **COPIES ONLY** of diagnostic tests including all films and corresponding reports.
4. This Authorization is restricted to records:____
____.

The following person or class of persons may receive disclosure of protected health information:

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel or revoke this authorization at any time by submitting a written request to you. However, I understand that any action already taken in reliance on the authorization cannot be reversed and my revocation will not affect those actions.
- The information to be used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.

This authorization **MUST BE AN ORIGINAL.**

Authorization to obtain records is provided based upon recipient's agreement to provide copies of all medical records received to the plaintiff.

This authorization shall remain valid until the claim has been legally concluded

The purpose of this request is for Litigation and any medical examinations, medical record reviews and physical injury evaluations in connection therewith.

____
Signature of Individual Date Date of Birth

____
Signature of Guardian/Personal/Legal Representative Date
Notary Public/Witness

This authorization must be completed in its entirety. A copy of this completed, signed and dated form must be given to the Individual or person signing on the Individuals behalf.

Note: Sections 17 and 18 of the Public Health Law limit the amount that can be charged for providing copies pursuant to this request to a reasonable charge not to exceed $.75 per page.

Specifically, this form complies with the Code of Federal Regulations Title 45, Part 164.508 pursuant to the Health Insurance Portability and Accountability Act of 1996 [HIPAA]. This form also complies with Sections 17 and 18 of the New York Public Health Law.