THE PLACE FIRM
PLAINTIFF LIEN RESOLUTION COUNSEL

David L. Place, Esq. Licensed in Kentucky and District of Columbia

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

In Compliance with HIPAA 45 CFR §164.508

Patient Name: ______

Social Security Number: ____-___-_____ Date of Birth: ___/___/_____

Personal Representative (if applicable): ______

Relationship to Patient: ______*Please provide Power of Attorney or Executor documentation*.

I give my expressed permission to ______(name of insurer, provider or other lienholder) to disclose all protected health information for the purpose of healthcare lien resolution to:

The Place Firm
1811 N. Dixie Avenue
Suite 104 PMB #106
Elizabethtown, KY 42701-5564

Phone: (270) 370-3317
FAX: (270) 246-9933

Information to be disclosed (check all that apply):

☐ Complete conditional payment or claim summary pertaining to patient date of loss ___/___/_____

☐ Entire patient medical records, treatment, patient history and any other documents relating to my medical care or treatment at any time.

☐ Health plan description for insurers who may have made payments for which subrogation may be required.

☐ Only the following limited records or information: ______

This protected health information is being used or disclosed for the following purpose: ______

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer be protected by these regulations.

I have the right to refuse to sign this authorization. I understand that authorizing the disclosure of my health information is voluntary. My refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits.

I have the right to inspect or copy the protected health information to be used or disclosed under this authorization. Unless otherwise revoked, this authorization will expire on ___/___/_____, or two years after the date of signature.

Finally, I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must send written notification to The Place Firm, 1811 N. Dixie Ave., Suite 104 PMB #106, Elizabethtown, KY 42701-5564. I also understand that any written revocation will not apply to actions taken by the requesting person/entity prior to the date the notification is received.

____ ______________________

Signature of Patient or Personal Representative Date