HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

TO: _____

Name of Healthcare Provider / Physician / Facility / Medicare Contractor

_____

Street Address / City / State / ZIP Code (OF PROVIDER) Phone No. of Provider

RE: _____

Patient Name Date of Birth Last four digits of SS#

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal proceeding. I expressly request that the designated record custodian of all covered entities under HIPPA identified above disclosure full and complete protected medical information including the following:

☐ All medical records, including but not limited to: office notes, medical history, consultation notes, treatment records, all clinical charts, reports, progress notes, social work records, clinic records, treatment plans, admission records, discharge summaries, test results, statements, photographs and other media (if related to condition or treatment).

☐ All therapy records. including but not limited to therapy / progress notes, assessments and intake documents.

☐ All records from any alcohol, drug or other substance abuse program including but not limited to assessments, progress notes, drug testing results and any other documents related to alcohol, drug, or other substance abuse treatment.

☐ Other Records (Describe):

I understand the information to be released or disclosed my including information relating to sexual transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: **use in a legal proceeding.**

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived. You are authorized to release the above records to the following individuals:

Christopher Tamms
Tamms Law Office, LLC **Phone: (614) 859-9529**
670 Meridian Way; Suite 120 **Fax: (614) 567-0031**
Westerville, Ohio 43082 **email: chris@tammslaw.com**

☐ **If this box is checked, I also authorize the above provider to speak with Christopher Tamms regarding the treatment of the above patient and the records provided regarding the above patient.**

Please Provide ☐ All relevant records in your possession OR ☐ records from _____ to _____

I understand the following: (1) I have a right to revoke this authorization in writing at any time, except to the extend information has been released in reliance upon this authorization. (2) The information released in response to this authorization may be re-disclosed to other parties. (3) My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy, or photocopy of this authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until one year from the date of execution at which time this authorization expires.

Authorizing Party (please print)
Name_____
Address _____
_____
_____
Relationship to Patient
_____

_____
Signature of Authorizing Party / Patient *

Date: _____

*****Should be signed by patient if adult or legal custodian if minor child