

**HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION
(execute a single form for each provider)**

TO: _____
Name of Healthcare Provider / Physician / Facility / Medicare Contractor

Street Address / City / State / ZIP Code (OF PROVIDER) PHONE

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 guardian ad litem investigation. 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, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse’s notes, social work records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires / histories, photographs, videotapes, and records received by other medical providers.
- All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
- All pharmacy / prescription records including NDC numbers and drug information handouts/ monographs.
- All counseling / therapy records. including therapy notes and progress notes
-

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**
5 West Main Street, 3rd Floor **Fax: (614) 567-0031**
Westerville, Ohio 43081 **email: chris.tamms@gmail.com**

If this box is checked, I also authorize the above provider to speak with the above individual regarding the content of the records disclosed.

Please provide records dated _____ to _____ OR all records for the above patient regardless of date if no date range is supplied

I understand the following: (1) I have a right to revoke this authorization in writing at any time, except to the extent 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 two years 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