HIPAA COMPLIANT MEDICAL INFORMATION RELEASE

Patient: _____ DOB: _____ SSN: _____

Health Care Provider: _____

1. AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION. This is to authorize any physician, hospital, laboratory, insurer, government agency, health care provider, employer, person or entity with any type of working relationship, present or past, to furnish any and all medical and billing information regarding myself or the person whose name appears above, for whom I have the legal authority to make this authorization to GREGORY MARSHALL, P.S., 3206 Wetmore Avenue, Suite 13, Everett, WA 98201, (425) 212-9945. The purpose of this authorization is for legal recourse and compensation.

2. NATURE OF INFORMATION TO BE DISCLOSED. GREGORY MARSHALL, P.S. and any representative on its behalf, is authorized to communicate directly with my healthcare providers, to obtain any and all health care information or opinions, and/or to view or receive any x-rays, hospital records, physician's records or any other health care information whatsoever.

3. RE-DISCLOSURE. I understand and authorize that GREGORY MARSHALL, P.S. may re-disclose information released to it and that privacy laws may no longer protect this information.

4. PSYCHIATRIC AND OTHER SENSITIVE RECORDS. If my medical records contain information relating to mental health, sexually transmitted disease, AIDS/HIV, or treatment for alcohol and drug abuse, I specifically authorize the release of this information.

5. COPY IN LIEU OF ORIGINAL. A copy or fax of this authorization shall have the same force and effect as the signed original.

6. REVOCATION OF OTHER AUTHORIZATIONS. I hereby revoke any other authorization for release of health care information that may have been provided to you by any insurance company, other attorneys, or other entity or person. Therefore, you are hereby directed not to release any information of any nature whatsoever to insurance adjusters, other attorneys, or their representatives without my written consent.

7. REASONABLE FEE. State law provides that a health care provider may charge a reasonable fee, not to exceed the health care provider's actual cost for providing the health care information. See WAC 246-08-400.

8. DURATION OF AUTHORIZATION AND RIGHT TO REVOKE. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I have the right to revoke this authorization at any time. If I revoke this authorization I must do so in writing, and the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in ninety (90) days.

_____ _____

Dated Patient or Authorized Person