

**CONSENT AND AUTHORIZATION TO RELEASE  
PROTECTED HEALTH INFORMATION AND RECORDS**

TO: \_\_\_\_\_  
(FACILITY)

RE: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Name of Patient (please print)

Pursuant to the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and specifically pursuant to 45 CFR §164.508, I hereby authorize and direct, if requested by the bearer, any physician, osteopath, chiropractor, hospital, clinic, emergency medical service, medical attendant, mental health provider, dentist, any other health care provider, past or present employer, to furnish to \_\_\_\_\_ of the law firm of \_\_\_\_\_, or their agents, for his/her/their copying or reproducing all records in your possession or under your control pertaining to the above individual. **I authorize and agree to release of all records including, but not limited to, material that contains information in reference to drug and/or alcohol abuse, psychiatric or psychological testing or care, sexually transmitted disease, Hepatitis B or C testing and HIV/AIDS testing.**

You are further authorized and directed, if requested by the bearer, to provide all original diagnostic films, photographs, radiographic materials, any and all tissue samples, slides, paraffin blocks, or other pathological materials pertaining to the above individual.

**The release of information is directed and authorized for purposes of investigation and discovery in civil litigation** in which the past, present and future physical and mental condition of the above individual is relevant. I understand that my healthcare will not be affected if I refuse to sign this authorization.

**You are specifically and expressly released from any liability which would otherwise arise from the release of this information;** and I waive, on behalf of myself and any persons who may have an interest in the matter, all provisions of law relating to the disclosure of confidential information. **I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and will no longer be protected by HIPAA.**

This authorization is intended to allow the release of existing records only and is not intended as a release to authorize or allow the verbal discussion of any injuries or treatment by any health care provider, with the bearer of this authorization. **This authorization is valid during the entire pendency of the litigation under which records are requested unless I specifically revoke, in writing, their authorized release. I hereby acknowledge that I have been notified that I have the right to revoke this authorization by submitting a notice in writing to the facility listed above.**

You are specifically and expressly authorized to accept a copy of this authorization as though it were an original.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE