

HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508

Name or specific identification of the person(s), or class of person(s), authorized to make the requested disclosure:

Patient Name:
Address:

Date of Birth:
SSN:

I hereby request and authorize the disclosure of all protected medical information for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of _____ to _____ including the following:

- All medical records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
- All radiology films, mammograms, myelograms, CT Scans, photographs, bone scans, pathology, cytology, histology, autopsy, immunohistochemistry specimens, cardiac catheterization videos, CDs, films, reels, and echocardiogram videos.
- All pharmacy/prescription records, including, but not limited to, NDC numbers and drug information handouts/monographs.
- All billing records including, but not limited to, all statements, itemized bills, and insurance records.

Information about alcohol/substance abuse and HIV/AIDS may be disclosed as follows (check all that apply):

Disclose HIV/AIDS information? YES NO
Disclose alcohol/substance abuse information? YES NO

I authorize you to release the protected information to my attorney(s) at the THE LAW OFFICE OF ANDREW G. GAY, JR., LLC, and/or any of their agents, 1731 Spring Garden Street, Philadelphia, PA 19130, (215) 545-7110 (telephone), (215) 545-7131 (facsimile).

This acknowledges the right to revoke this authorization by writing to the Law Office of Andrew G. Gay, Jr., LLC at the above address. However, I understand that any actions already taken in reliance of this authorization cannot be reversed, and my revocation will not effect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and may no longer be protected under 45 CFR 164.508. I further understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization.

Any facsimile, copy or photocopy of this authorization shall permit you to release the records herein. This authorization expires two (2) years from the below date, unless sooner revoked in writing.

Signature: _____ Date: _____
Relationship to person who is the subject of records: Self _____ Other: _____
Described Authority: _____