HIPAA-COMPLIANT AUTHORIZATION FOR RELEASE OF INFORMATION

1. I (the undersigned) authorize the following entities: _____ _____

   To release information from the record(s) of: _____
   (Patient First Name, Middle Initial, and Last Name)

   DOB: ____/____/_____ SSN: _____ - ____ - _____ Covering the period(s) of treatment: _____ to Present

2. REQUESTING **MEDICAL RECORDS AND BILLING RECORDS**

3. Information to be released: ☑ ALL RECORDS as listed below OR ☐ SELECTED RECORDS as listed below (Check all that apply):

1. Patient data cover sheet.
2. Nurses' admitting notes.
3. History and physical.
4. Doctors' order sheets.
5. Doctors' progress notes.
6. Outpatient clinic records
7. Office notes.
8. Visiting nurses' records.
9. Ambulance records.
10. Nurses' medication records.
11. Vital signs charts.
12. Code blue Sheet/CPR Method.
13. Nurses' notes.
14. All incident reports.
15. Pre-op check list.
16. Surgical consent forms.
17. Operative reports.
18. Personal property lists.
19. Paramedic reports.
20. Pathology/independent pathology reports.
21. Autopsy reports.
22. Medical Examiner's reports.
23. All Lab Reports: (a) White count, differential, hemoglobin, SED rate; (b) Bacteriology, epidemiology, anaerobic, aerobic, acid fast, fungal; (c) Spinal fluid, blood gasses; (d) Bleeding and clotting time; (e) Blood reactions testing/type and cross match; (f) EMG, EEG, EKG, Echo-ultrasound, doppler testing; (g) Blood volume, electrolytes; (h) Fluid input and output; (i) Skin allergy testing; (j) Invasive/Noninvasive CVP, PWP, arteriole line pressure. (k) Respiratory function studies/spirometry; (l) Fetal monitor tracings; (m) Other.
24. Blood transfusion slips.
25. Anesthesia record.
26. X-ray reports.
27. Consultation reports: (a) Neurology; (b) Psychiatry; (c) Internal Medicine; (d) Orthopaedic; (e) Surgical; (f) Obstetric; (g) Pediatric; (h) Neurosurgical; (i) Neonatologist; (j) Other.
28. Myelogram.
29. Risk Manager's Patient Safety Report.
30. Scans, CAT, CT, ultrasound.
31. Arteriograms, venograms, angiograms
32. Recovery room records.
33. Discharge summaries.
34. Discharge or transfer instructions or data.
35. Nurses' OR record.
36. Post-op instrument count record, sponge count record.
37. Photographs.
38. ER records.
39. Labor and Delivery Room records.
40. Pharmacy reports/Unit Dose Control Sheet.
41. Physical therapy sheet notes.
42. Respiratory therapy sheet notes.
43. Hospital bills, insurance forms, records of payment.
44. x-ray films, including any and all radiographic studies.
45. Record of operative procedure.
46. Any other records, reports, memoranda, documents, correspondence, etc.

3. Information is to be released to:

4. Purpose of disclosure: Litigation

5. I understand this consent may be revoked/reviewed in writing at any time. With the exception to the extent that disclosure of information has already occurred prior to the receipt of revocation by the above named provider. If written revocation is not received, authorization will be considered valid for a period of time not to exceed 2 years from the date of signing. To initiate revocation of this authorization direct all correspondence to the “Specific Requestor" above.

6. I understand that this consent is to include disclosure of:

   ☑ Alcohol and/or drug abuse record ☑ Psychiatric records

   ☑ Sexually transmitted disease information ☑ HIV/AIDS information

7. A photocopy of this authorization is to be considered as valid as the original.

8. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law.

9. The covered entity may not withhold/condition treatment, payment, or eligibility for benefits on obtaining the authorization or if patient refuses to sign this authorization.

10. I have the right to receive a copy of this authorization.

    SIGNATURE: _____ Date: _____

    Patient or personal/legal representative (Next-of-kin or legal guardian to sign only if patient is a minor, legally incompetent, or deceased)

    PRINT NAME:_____

    Relationship to patient (if not patient): _____