

**Authorization for Disclosure of Protected Health Information**  
**Pursuant to HIPAA 45 C.F.R. 164.512**

I authorize the use/disclosure of health information as described below.

1. Person(s) or class of persons authorized to disclose the information:

\_\_\_\_\_

2. Person(s) or class of persons to whom the information may be disclosed: I understand that this may include information relating to acquired immunodeficiency syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus), psychiatric care, treatment for alcohol and/or drug abuse, and/or genetic testing.

3. Description of information to be disclosed: Medical records and reports, patient information and history forms, x-rays, x-rays reports, pathology, pathology reports, insurance records, health care providers' reports and consultations, prescriptions, off-work slips, therapy records, lab reports, notes, tests and billing records and statements. From \_\_\_\_\_ to \_\_\_\_\_ (dates).

4. The information will used/disclosed for the following purposes: Use for discovery purposes and as evidence in the lawsuit styled: \_\_\_\_\_  
(the "Lawsuit").

5. I understand that the health information described above may be redisclosed and no longer protected by federal and state privacy regulations.

6. I understand that my healthcare or payment for healthcare will not be affected if I refuse to sign this authorization.

7. In consideration of the release of information by \_\_\_\_\_ in accordance with this request, I hereby release \_\_\_\_\_ its agents, servants, and employees from any and all claims, demands, or liability of any kind, which might arise out of the release of such information and the effects thereof.

I understand that I have the right to revoke this authorization in writing at any time by sending written notice of revocation to: (persons listed in paragraph 1). I understand that my revocation of this authorization will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organizations listed above have already made in reference to this authorization.

This authorization expires 150 days from the date signed.

\_\_\_\_\_  
Signature of patient or personal  
representative

\_\_\_\_\_  
If signed by personal representative  
state authority (ex. Power of Attorney).

\_\_\_\_\_  
Printed name of patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of birth of patient

\_\_\_\_\_  
Social Security  
Number of patient

\_\_\_\_\_  
Former/alias maiden name of patient