HIPAA MEDICAL RELEASE FORM

I intend for any agent named in this release to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable Protected Health Information (PHI) and other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d and 45 C.F.R. 160-164.

I authorize _____
(name of health care provider) to disclose of any PHI governed by HIPAA to be provided to the following agent(s): The Gordon Law Firm, P.C., and any agents or employees of said Firm. Said information and records are to be used for legal proceedings.

Accordingly, I hereby authorize any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to any agent who is named herein and who is currently serving as such, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. I hereby release from liability for disclosure any person, firm, or entity that releases said PHI in response to being provided a copy of this document.

This authority given to any named agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. I understand that the individually identifiable health information and other medical records given, disclosed, or released to any named agent may be subject to redisclosure by a named agent and may no longer be protected by HIPAA. The authority given to any named agent herein has no expiration date and shall expire only in the event that I revoke this HIPAA Release in writing and deliver it to my health-care provider. I understand that I do not have to sign this form in order to ensure my right to receive medical treatment, or ensure payment of my healthcare expenses. I also understand that I have the right to revoke this HIPAA Release at any time, but if I do revoke said authorization, I must do so in writing and present said revocation to the physician or healthcare provider who has released said information. I further understand that said revocation will not apply to information already released prior to revocation.

This authorization includes the release of documents in your possession whether or not created in your office or by another healthcare provided. You are authorized to comply with an original or copy of this authorization form.

_____ _____
Signature DOB

_____ _____
Printed Name Social Security #

_____ _____
Patient's Representative Date