**LIMITED AUTHORIZATION TO INSPECT AND COPY MEDICAL RECORDS**
**(Valid for 60 days from date)**

TO WHOM IT MAY CONCERN:

I, _____, hereby authorize all doctors who have ever treated me and all doctors who have ever treated me and all hospitals at which I have ever been a patient to permit _____ or his/her/its attorney or representative, by presenting this signed authorization or a copy thereof, to such doctor or hospital, to obtain a copy of all of said medical records of any nature whatsoever (including medical bills and existing medical opinions) pertaining to any diagnosis, examination, and treatment of me at any time at such hospital or by such doctor or at his direction.

This is not an authorization permitting anyone to orally discuss my medical treatment or condition with my doctors or the doctor's personnel.

I give this authorization with the following understanding and agreement of counsel:

1. That _____ will deliver to my attorney, _____, at reasonable cost to me, a copy of all records and documents obtained by use of this authorization;

2. That _____ shall advise my attorney in writing of all medical providers to whom this authorization is presented, regardless of whether or not medical records are actually reviewed and/or copied. Such writing shall

   (a) identify the medical provider;

   (b) give the date of presentation of this authorization;

   (c) state the name of the person presenting the information and things obtained;

3. That _____ shall provide all copies and advisories herein within 20 days from the date of receipt of same.

HIPAA Release Authority. My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or 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 CFR 160 through 164. I 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 my agent, 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 of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

SIGNED AND DATED this the _____ day of _____, 20_____.

_____
SIGNATURE

_____
SOCIAL SECURITY NUMBER