AUTHORIZATION FOR MEDICAL INFORMATION

(Complete copies of all medical records)

NAME: _____
DATE OF BIRTH: _____
SOCIAL SECURITY: _____
DATE: _____

TO: ANY PHYSICIAN, HOSPITAL OR CLINIC

This is to advise that I have employed the firm of _____, to represent me in connection with a claim for injuries, which I have sustained on or about the _____ day of _____, 20_____, which said injuries were the subject of the treatment and examination by professionals while at your facility. My attorneys are desirous of obtaining information as to the examination and treatment of me for those injuries, and I hereby consent and authorize you to turn over to them or any individual in their office, any information which you have concerning my said injuries and the examination or treatment thereof. I request that you allow them to view your records concerning these injuries and talk with you about it and request your cooperation with them.

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.

I HEREBY REVOKE ALL PRIOR AUTHORIZATIONS, EXCEPT THOSE AUTHORIZATIONS BY INDIVIDUALS, PARTNERSHIPS, CORPORATIONS OR OTHER ENTITIES WHO ARE PROVIDING COMPENSATION FOR HEALTH CARE SERVICES, WHICH HAVE BEEN PROVIDED IN MY BEHALF REGARDING THE ABOVE REFERENCED INJURIES. ALL AUTHORIZATIONS BY ANY OTHER PARTNERSHIP, FIRM OR CORPORATION ARE HEREBY REVOKED. THIS AUTHORIZATION REQUESTS ALL OF THE AFOREMENTIONED MEDICAL INFORMATION PRIOR TO THE DATE OF THIS DOCUMENT'S EXECUTION WITH SAID AUTHORIZATION EXPIRING THREE YEARS FOLLOWING THE DATE OF THIS DOCUMENT'S EXECUTION.

Sincerely,

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