Hausmann
& Hickman, P.A.
ADOPTION & REPRODUCTIVE LAW

Michelle M. Hausmann, Esq.*
Amy U. Hickman, Esq.*

* Board Certified in Adoption Law
* Members of the American Academy of Adoption Attorneys

SURROGATE MEDICAL RECORDS RELEASE

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Soc. Sec. Number: _____

Date of Birth: _____ Health Rec. # (if known): _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:

_____

Address _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ problem list
☐ list of allergies
☐ medication list
☐ immunization record
☐ most recent discharge summary
☐ bills, invoices, itemized statements
☐ most recent history and physical
☐ insurance claim forms
☐ laboratory results from (date) _____ to (date) _____
☐ x-ray and imaging reports from (date) _____ to (date) _____
☐ consultation reports from (doctors' names) _____
☐ entire record from (date) _____ to (date) _____
☐ other _____

_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

HAUSMANN & HICKMAN, P.A.
MICHELLE M. HAUSMANN, ESQ.
AMY U. HICKMAN, ESQ.
2423 Quantum Blvd.
Boynton Beach, Florida 33426

for the purpose of: a Surrogacy Matter.

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to **Hausmann & Hickman, P.A.** I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Hausmann & Hickman, P.A. or an independent attorney.

_____ _____
Patient Date

_____ _____
Signature of Witness Date

STATE OF _____)

COUNTY OF _____)

I HEREBY CERTIFY that on this day, before me, the undersigned Notary Public, personally appeared _____, who well known to be the person described in or who has produced _____ as valid identification and who, after first being duly sworn, deposes and states that he/she executed the foregoing authorization to disclosure health information before me and that he/she executed same freely and voluntarily for the purposes therein expressed.

SWORN TO and subscribed before me this _____day of _____, _____.

_____

Notary Public

State of