HIPAA COMPLIANT
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient name: Health Record Number
Address:
Date of Birth:

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)
__*XX*__ ***ENTIRE RECORD – Duly Certified to be a TRUE & ACCURATE COMPLETE copy.***

____ problem list
____ medication list
____ list of allergies
____ immunization record
____ most recent history and physical
____ most recent discharge summary
____ laboratory results from to
____ x-ray and imaging reports from to
____ consultation reports from (doctors' names)
____ other - ***ALL***

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (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
Goldsmith & Goldsmith 140 Sylvan Avenue, Englewood Cliffs, New Jersey 07632 and/or Mediconnect.net, Inc., c/o RapiDisclose 10705 South Jordan Gateway, Suite 100, South Jordan, Utah 84095 for the purpose of: possible litigation

6. I understand I have the right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. 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: not applicable. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

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 HIM Director, privacy officer, or other office or individual's name or contact information.

8. I understand that N.J.A.C. §13:35-6.5(c) and N.J.A.C. §8:43G-15.3 require that physicians and hospitals fulfill medical record requests within thirty (30) days and limits the fees that can be charged for copying said medical records. I hereby authorize Goldsmith Richman & Harz, LLP to file suit against the physician and/or hospital that violates these regulations.

_____ _____
Signature of patient or legal representative Date

_____ _____
If signed by legal representative, Signature of witness
Relationship to patient