

## Authorization to Disclose Health Information

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR § 164.508

**Record Subject:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Social Security:** \_\_\_\_\_  
**Name of Facility to Release the Information:** \_\_\_\_\_  
**Address:** \_\_\_\_\_

**Information to be Released:**

From (date): \_\_\_\_\_ To (date): Present \_\_\_\_\_

***Please check type of information to be released:***

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Pathology Reports       | <input type="checkbox"/> Diagnosis & Treatment Codes     |
| <input type="checkbox"/> Discharge Summary         | <input type="checkbox"/> Medication Reports      | <input type="checkbox"/> Photographs, Video & Audiotapes |
| <input type="checkbox"/> Consultation Reports      | <input type="checkbox"/> Progress Notes          | <input type="checkbox"/> Nurses Notes                    |
| <input type="checkbox"/> Operative Reports         | <input type="checkbox"/> Laboratory Test Results | <input type="checkbox"/> Radiology Films/Images          |
| <input type="checkbox"/> Radiology Reports         | <input type="checkbox"/> Itemized Bill           | <input type="checkbox"/> <b>Entire Record</b>            |
| <input type="checkbox"/> Other (specify): _____    |  |  |

**Purpose of Request:** For potential use as evidence in a legal proceeding

**Who and Where to Send / Released Information:**

**Name:** Stephens & Stephens **Acting as Agent for:** \_\_\_\_\_  
**Address:** 6310 Olde Pecan Drive, Suite 200, Richmond, Texas 77406

**Time Limit & Right to Revoke Authorization:**

I understand that 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 the facility authorized to make the disclosure named above. I understand that 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 three (3) years from the date of signature or at such time as the cause of action for which this release was originally requested is finally adjudicated by Order of the Court in which litigation is pending. A photocopy of this authorization shall have the same authority as the original.

**Re-Disclosure:**

I understand the information disclosed by this authorization may be subject to re-disclosure and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

**Signature of Patient or Personal Representative Who May Request Disclosure:**

I understand that I do not have to sign this authorization. I need not sign this form in order to assure treatment. I understand that I can inspect or copy the information to be used or disclosed. I understand that this authorization authorizes the release of all medical or billing records including Psychiatric, Alcohol, Drug Abuse, and Human Immunodeficiency Virus (HIV) / Acquired Immunodeficiency Syndrome (AIDS) records.

\* I Authorize the Above Named Facility to Release the Protected Health Information Specified Above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_