THE CENTERS

PATIENT AUTHORIZATION FOR THE
RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
(HIPAA COMPLIANT)

Patient's Name: _____ Date of Birth: _____

Social Security Number: _____

1. I authorize _____ to release any and all records pertaining to the above named individual's health information as described below.

2. This information for which I'm authorizing disclosure will be used for the following purpose: "at the determination of the individual or organization in bullet 4 on the following page".

3. The type of information to be used or disclosed is as follows:

Complete medical record/chart	Laboratory results and reports
Complete hospital record	Patient information
Complete physician record(s)	History questionnaires
Complete surgeon record(s)	History & physical information
Consultation records	Discharge summaries
Operative reports	Progress Notes
Physical therapy records	Prescriptions/Medications
Other therapy records	Nurse(s) Notes
X-rays, CT scans, MRIs, PET scans	Correspondence
Diagnostic imaging reports	Consents for treatment
Diagnostic monitoring data	Itemized billing statements

Any other materials (whether written or stored, created or maintained in any other form, including electronic) relating or pertaining to this patient, including documents and records received from or created by another provider.

I understand that the information in my health record may include information related 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.

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4. The information identified above may be used by or disclosed to the following individual or organization:

   The Center for Litigation Support
   4912 Creekside Drive
   Clearwater, Florida 33760
   Fax: (844) 257-9687

5. I understand that I have a 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 that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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.

6. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

7. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

8. I understand that this authorization will expire on _____, one (1) year from the date of this signed authorization.

_____ _____

Signature of Patient or Representative Date

If signed by representative, relationship to patient _____