

## **HIPAA Authorization to Disclose Protected Health Information**

I hereby give permission for my personal medical information to be used and given out as described below.

Patient Name: \_\_\_\_\_

Patient Social Security Number: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

The following person(s) or organization(s) are permitted to provide the information:

\_\_\_\_\_  
\_\_\_\_\_

The following attorney(s) or law firms(s) are permitted to receive and use the information (name, address and telephone number):

\_\_\_\_\_  
\_\_\_\_\_

The above-named attorney(s) and law firm(s) are permitted to receive the information and are hereby appointed as my representative pursuant to La. R.S. 40:1299.96(A)(2)(b) for the limited purpose of obtaining and using any and all information the releasing person(s) or organization(s) may have concerning treatment or services rendered to the undersigned for any reason, including but not limited to notes (handwritten and/or typed), charts, medical reports, face sheets, discharge summaries, history and physical, consults, laboratory results, reports of x-rays and copies of any and all actual films and/or x-rays, outpatient records, test results, operative reports, pathology reports, physician orders, progress notes, emergency records, therapy records, nurse's notes, opinions, diagnoses, prognoses, histories, statements and/or bills, correspondence, pharmaceutical records, including but not limited to date of prescription, prescribing physician, name of drug, dosage and amount dispensed, and/or any other medical information regarding any treatment, whether inpatient or outpatient. This specifically includes documents to and from other health care providers, attorneys, insurance companies, etc.

The information will be used or given out for the purposes of handling the attorney's or law firm's duties in the investigation and possibly litigation of claims in which I am involved. This authorization is initiated at my request and the health information will be disclosed at my request. Health information released as a result of this authorization may be re-disclosed or shared by the persons or organizations receiving the information and might not be protected by federal or state regulations upon such disclosure.

I understand that I may refuse to sign this authorization. I further understand that my refusal to sign will not affect my ability to obtain treatment unless a third party requests that treatment and/or release of information.

I understand that I may revoke, or withdraw, this authorization at any time by sending a written notice to the above-named person or organization authorized to release the information. This revocation will be effective for future uses and disclosures of the information described above. The revocation will not have any effect on information already used or given out.

This authorization expires upon final resolution of the litigation entitled:

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I authorize the release of records only, and do not authorize oral communications by the health care provider to the authorized requesting person(s) or organization(s).

The authorized requesting party shall provide to me or my attorney a copy of this authorization at the same time the authorization is provided to the health care provider(s) authorized above to release information.

The authorized requesting party shall mail to me or my attorney a copy of all records received pursuant to this request within seven days of receipt of the information.

A photocopy of this form will serve as an original.

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Signature of Patient or Representative

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Date

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Printed Name of Patient

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Relationship to Patient if Signed by Representative

A copy of this completed form must be given to the patient or the person signing on the patient's behalf.