AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION UNDER FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA)

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may be subject to re-disclosure and may no longer be protected by federal privacy regulations, including HIPAA. I hereby release the organization providing this information from any legal responsibility or liability for disclosure of this information to the extent indicated and authorized herein.

Patient Name:_____ **ID/SS #:** _____

Patient Address: _____ **Date of Birth:**___/___/____
(Street/City/State/Zip)

Persons/organizations providing the information: _____
(Medical Provider Name/Practice Name)

Persons/organizations receiving the information: (Send to)

Christopher R. Nichols, Attorney At Law
106 Kipling PL, Suite 100, Raleigh, NC 27609
Phone: 919-915-0212 Fax: 919-510-0170
email: nicholsatty@gmail.com

Specific description of information, covering health care from_____**to**_____**:**
(Start Date) (End Date)

☐Complete health records and bills(prescription bills, history and physical, discharge summary, operative reports, consultation reports, radiology and imaging reports), excluding all images (x-rays, photographs, etc.)

☐Other (please specify) _____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on July 22, 2008 **Initials:**_____

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing and that, if I do revoke this authorization, this will not have any affect on any action the providing organization takes before receiving the revocation. **Initials:**_____

3. I understand that I have the right to refuse to sign this Authorization. **Initials:**_____

4. I understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law. **Initials:** _____

5. I understand the data release may include material protected by law including Mental Health, Drugs and Alcohol, HIV/AIDS and other communicable diseases and Genetic Testing. **Initials:**_____

I have read and understand the information in this Authorization.

X_____ **Date:**_____
Signature of patient or patient's representative
(*Form MUST be completed before signing.)*

Printed name of patient's representative: _____

Relationship to the patient:_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION