

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

TO: _____

PATIENT INFORMATION:

Patient Name: _____

Date of Birth: _____ SS#: _____

I, _____, authorize and direct you to release my entire medical and billing file, including but not limited to all medical records, labs, billing ledger, physician orders, medications, etc., to:

RECIPIENT INFORMATION:

Name: LAW OFFICE OF CHAD A. BARR, P.A.
Address: 286 DOUGLAS AVE, SUITE 100, ALTAMONTE SPRINGS, FL 32714
Phone: 407-599-9036 FAX: 407-960-6247

SPECIFIC DOCUMENTS TO BE RELEASED:

- | | | |
|---|---|--|
| <input type="checkbox"/> ALL Records | <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> History/Physical | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Consultation |
| <input type="checkbox"/> Labs | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Cardiology Reports | <input type="checkbox"/> Nurses Notes |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Itemized Bills | |

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (initials)

This request is authorized to include any federal and/or state protection under Florida Statutes 394.459(9) Psychiatric Information, 397.053/396.112 Drug and Alcohol Abuse Information 381,609 HIV and AIDS related conditions and/or 397.50(3) records of minor client.

PURPOSE FOR INFORMATION:

- Continued Medical Care Insurance Personal Current Litigation

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 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 in one year.

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.

SIGNED: _____ Date: _____