H.I.P.A.A. AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name:		Date of Birth:	
		Social Security Number:	
Address:			

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

X Complete medical/health records (including all treatment notes, diagnostic reports, narrative reports, referral records, prescription notes and diagnostic images),
X Complete billing records (including itemizations of gross expenses, credits and third party payments/contributions).

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

5. This information should be disclosed to and used by the following individual or organization and I request that my **FREE COPIES** of all documents be provided to them pursuant to KRS 422.317, 422.300 and 422.350 (if applicable).

BRIAN SCHUETTE
CRAIN | SCHUETTE ATTORNEYS
719A Dishman Lane
Bowling Green, KY 42104
270-781-7500, 270-781-7533 fax
info@csafirm.com

6. This information is requested by the patient for legal purposes, possibly litigation.

7. 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 my insurance company when the law provides my insurer with the right to contest a claim under my policy. I acknowledge that treatment cannot be conditioned upon my signing this authorization.

8. If I fail to specify an expiration date, event or condition, this authorization will expire in six months. Unless revoked, this authorization will only expire on the following date, event, or condition: **Termination of representation by CRAIN SCHUETTE ATTORNEYS.**

9. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. No medical provider may condition treatment, payment, and enrollment in its health plan, or eligibility for benefits on my signing his authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that 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.

10. **A photocopy or facsimile of this document shall have the same validity, force and effect as the original from which it is taken.**

_____ _____
Signature of patient or legal representative Signature of witness:

Date: _____ Date: _____

SUBMIT DOCUMENT