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

1. Patient Name (please print): _____

   Address: _____

   Date of Birth: _____ Social Security #: _____

2. I authorize the use or disclosure of the above-named individual's health information as described below. This information may be disclosed to, and used by, the following individual(s) or organization(s):
   The Law Office of Grant Skolnick,
   Mailing Address: 2728 SW 23rd Cranbrook Drive, Boynton Beach, FL 33436,
   Phone # (561) 602-1776, Fax #: (561) 420-0123, Email: Lawyer@GrantSkolnick.com

3. The following individuals or organizations are authorized to make the disclosure:

   Name: _____

   Address: _____

   Telephone #: _____

4. The protected health information released herein is specifically as follows :
   (Check the appropriate boxes)

□ All Medical records pertaining to hospitalization from _____ to _____
□ Problem List
□ Medication List
□ List of Allergies
□ Immunization Record
□ Most Recent History and Physical
□ Most Recent Discharge Summary
□ Laboratory Results from _____ to _____
□ X-ray and/or imaging reports from _____ to _____
□ Consultation Reports from _____
□ Entire Record
□ Billing Information
□ Other (please describe): _____

5. I understand that the information in my health records may include information relating to sexually transmitted disease(s), human immunodeficiency virus (HIV) and/or acquired immunodeficiency syndrome (AIDS). It may also include information about behavioral or mental health services and treatment for alcohol and/or drug abuse.

6. This protected health information is to be used for the following purpose:
For representation in a personal injury case.

7. I understand that a refusal to sign this form will not result in a denial of health care by the hospital or any other health care provider, and that this release has not been coerced by a health care entity or any of its business associates.

8. This release may be revoked by a signed and properly dated written revocation, delivered to the hospital or health provider, *provided* that this release cannot be revoked as to protect health information that had been previously released in reliance on this document.

9. I understand that once the PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, insurance companies and even may become public record if filed with a court of law.

10. Unless otherwise revoked, this authorization will expire on the following date, event or condition:
Upon the conclusion of my personal injury case.

Dated this _____ day of _____, 20_____.

_____
Signature of Patient or Personal Representative

If executed by a personal representative, the representative's authority to act on the patient's behalf is:
_____ (e.g. "as parent" or "as legal guardian.")