Authorization for Release of Medical Records

HIPAA Compliant/Pursuant to 45 CFR 164.508

TO: _____
Name of Healthcare Provider/Physician/Facility

_____
Street Address

_____
City, State, and Zip Code

RE: _____
Patient Name

_____
Street Address

_____
City, State, and Zip Code

_____ _____
Date of Birth Social Security Number

I authorize the disclosure of all protected health information and I expressly request that the designated records custodian of all covered entities under HIPAA identified above disclose full and complete protected health information including the following:

☐problem list
☐medication list
☐list of allergies
☐immunization record
☐most recent history and physical
☐most recent discharge summary
☐laboratory results from (date) _____ to (date) _____
☐x-ray and imaging reports from (date) _____ to (date) _____
☐consultation reports from (doctors' names) _____
■ entire record
☐other

_____

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.

This information is for litigation purposes and may be disclosed to and used by the following individual or organization.

Kearns Duffy & Vaccaro, P.C.

3648 Valley Road, P.O. Box 56
Liberty Corner, New Jersey 07938

I understand 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 on the following date, event, or condition. **FINAL CONCLUSION OF MY PERSONAL INJURY/ WORKERS' COMPENSATION ACTION.**

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 or information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my attorneys for legal advice.

By signing below, I hereby authorize you to accept a photocopy of this authorization as an original.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness