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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

IN RE PATIENT: ____

DATE OF BIRTH: ____________________________ SOCIAL SECURITY NUMBER: ____________________________

ADDRESS: ____

TREATMENT DATE(S): ____

PURPOSE OF DISCLOSURE: LEGAL REVIEW Date Needed by (Court Date/Deadline): __________

Please release medical information to: Christine LaSalvia at the address listed above.

PLEASE PROVIDE CERTIFIED COPIES, IF CERTIFICATION IS AVAILABLE PLEASE PROVIDE REQUESTED DOCUMENTS STORED IN ANY AND ALL ELECTRONIC FORMATS UTILIZED BY YOUR FACILITY, AS WELL AS PAPER FORMAT, WHETHER ON MAIN PREMISES, SATELLITE OFFICE OR OFF-SITE STORAGE PLEASE PRINT EACH ENCOUNTER SEPARATELY AND/OR COPY IN CHRONOLOGICAL ORDER.
PLEASE REDUCE TO 94%

_____ Complete Hospital Chart

_____ Physicians Office Records

_____ Labs (Please include time and date for all requested labs)

_____ Itemized Patient Bill for Services

_____Other:____

____

This Authorization form may not be used for release of Psychotherapy Notes.

HIPAA COMPLIANT SECTION:

I, the undersigned, authorize ______________________________ (disclosing institution) and its employees to release information from my medical records as described above to my attorney, Christine LaSalvia. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immunodeficiency Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse or diagnostic records protected under the regulations in Code 42 of Federal Regulations, Part 2. Information in the form of audio, photo or video has been designated above, if applicable. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

This authorization for release of information is valid for one year from the date of signature, unless revoked by written notice to the Disclosing Institution, provided the said notice of revocation is received prior to release of information. If you need assistance in revoking this authorization, please contact the disclosing institution directly.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditional based on my signing this authorization.

As a professional courtesy, no cost is assessed for information released directly to your health care provider. All other releases are subject to a reasonable based fee. I understand there may be charges for the copying and release of information and accept financial responsibility.

A *photocopy of this signed authorization is valid as the original.* Please attach your invoice for any duplication cost. Thank you for your attention to this matter.

X____________________________________ ____________________________________ ________________
Signature of Patient/Legal Representative Printed Name Date Signed

X____________________________________
Relationship, if not patient

If other than patient's signature, a copy of legal documents MUST accompany the authorization when presented; Exception: parent signing for patient under the age of 18.