

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
UNDER FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996
(HIPPA)**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may be subject to re-disclosure and may no longer be protected by federal privacy regulations, including HIPAA. I hereby release the organization providing this information from any legal responsibility or liability for disclosure of this information to the extent indicated and authorized herein.

Patient Name: _____ ID/SS #: _____

Patient Address: _____ Date of Birth: ____ / ____ / ____
(Street/City/State/Zip)

Persons/organizations providing the information: _____
(Medical Provider Name/Practice Name)

Persons/organizations receiving the information: (Send to)

David R Payne, Attorney At Law
1 North Pack Square, Suite 425
Asheville, NC 28801
Phone: 828-258-0076 Fax: 828-281-2873
email: dpayne@drplawfirm.com

Specific description of information, covering health care from _____ to _____
(Start Date) (End Date)

- Complete health records and bills (prescription bills, history and physical, discharge summary, operative reports, consultation reports, radiology and imaging reports), excluding all images (x-rays, photographs, etc.)
- Other (please specify) _____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on _____ Initials: _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing and that, if I do revoke this authorization, this will not have any affect on any action the providing organization takes before receiving the revocation. Initials: _____
3. I understand that I have the right to refuse to sign this Authorization. Initials: _____
4. I understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law. Initials: _____
5. I understand the data release may include material protected by law including Mental Health, Drugs and Alcohol, HIV/AIDS and other communicable diseases and Genetic Testing. Initials: _____

I have read and understand the information in this Authorization.

X _____ Date: _____
Signature of patient or patient's representative
(Form MUST be completed before signing.)

Printed name of patient's representative: _____

Relationship to the patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION