

AUTHORIZATION TO RELEASE HEALTH INFORMATION

TERRY A. FRIEDMAN, ESQ.
LICENSED IN NEVADA AND ARIZONA

Patient Name: _____ Health Record No: _____
Date of Birth: _____
Social Security Number: _____
Date of Incident: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below:
2. The following medical facility, individual or organization is authorized to make the disclosure:

Address: _____

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

- medical treatment billing from _____ to _____
- itemized medication list including billing amounts from _____ to _____
- medical treatment records, reports and narratives from _____ to _____
- admit and discharge summaries from _____ to _____
- laboratory results from _____ to _____
- x-ray and imaging reports from _____ to _____
- consultation reports
- entire record
- other _____

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 may be disclosed to and used only by The Law Offices of Terry A. Friedman, Ltd. and its representatives at 518 Pyramid Way, Sparks, Nevada 89431, (775) 322-6500.

6. I understand I have the right to revoke this information 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 that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked this, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. 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 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 un-authorized re-disclosure, and the information may not be protected by federal confidentiality rules. I understand that this authorization is extended to and includes photostatic copies of this same executed medical release. If I have questions about disclosure of my health information, I can contact my medical/healthcare provider's custodian of records and/or billing departments.

Signature of Patient, or legal representative
If legal representative, relationship to patient:

Date

Witness