

General Authorization For Use and Disclosure

TO:

NAME:

ADDRESS:

SSN:

DATE OF BIRTH:

D/A:

Relationship to Participant: ___self ___spouse ___eligible dependent

I authorize the release of my medical records to:

State Relationship:

All of my Protected Employee Information

For the purpose(s) of (check all that apply):

___ Medical Care

___ Personal

___ Insurance Eligibility/Benefits

___ Legal Investigations/Action

___ At my request

___ Other (specify): _____

I understand that the health information disclosed as a result of this Authorization may no longer be protect by the federal privacy standards, and may accordingly e re-disclosed by the recipient without obtaining my Authorization.

I understand that I am under no obligation to sign this Authorization, and that the Law Firm may not condition my treatment, payment, enrollment in any plan, or eligibility for benefits on my decision to sign this form.

I understand that I have the right to revoke this Authorization. I further understand that withdrawal of this authorization will not be effective until received by the Privacy Officer and will be prospective only.

This Authorization is good for 90 days from the date It is signed.

I have had the opportunity to review and understand the content of this Authorization Form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient

Date

(If signed by someone other than the Participant, state your relationship and authority to do so.)

On this ____ day of _____, 200_, before me personally came who is known to me to be the person who signed the above Authorization Form (HIPPA).

Notary Public