HIPAA Privacy Authorization
For Disclosure of Protected Health Information
Relevant To Litigation or Pending Claims

Patient's Name: _____

Address: _____ Date of Birth: _____

1. I make this Authorization for the purpose of copying records in connection with a lawsuit or claim to which I am a party.

2. This authorization is directed to and applies to protected health information maintained by:

(Hospital, Physician, Medical provider, etc.) _____

_____

_____

_____

_____

3. I hereby authorize the above, its director, administrative and clinical staff or assignees, medical information services and billing departments to release any and all medical records and information from my date of birth to the present unless specified otherwise, relating to my care and treatment including x-rays, photographs, electronic and digital files and any other records, unless I expressly direct or specify otherwise. I understand that medical information may include records, if any, relating to treatment for alcohol and drug abuse protected under the regulations in 42 C.F.R. Part 2; psychiatric/psychological services and social work records and any information regarding communicable diseases and infections, tuberculosis, venereal diseases, sexually transmitted diseases, acquire immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or ARC.

4. This information is to be released for copying purposes to:

_____ or

their agent, **RECORD COPY SERVICES** .

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the Federal Privacy Rules.

6. This authorization shall be in force and in effect until the conclusion of the pending litigation or claim unless otherwise specified.

7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and send it to the hospital, doctor or other custodian of medical information. I understand that the revocation will not apply to information that has already been released in response to this authorization.

8. I understand that authorizing the release of this health information is voluntary and that I need not sign this form in order to ensure health care treatment, eligibility for benefits, payment or health plan enrollment.

9. A copy of this authorization is as valid as the original.

All Pertinent Sections Of This Form Must Be Completed Before Signing

Subscribed and sworn before me this
_____ day of _____, 20____

_____*Notary*
_____*County, PA*

My commission expires _____

X_____ _____
Signature of Patient or Legal Representative **Date**

_____
Print Name of Patient or Legal Representative

_____
Description of Legal Representative's Authority or Relationship