MEDICAL/RECORDS AUTHORIZATION
Compliant with 45 CFR 164.508 (a)(2)

TO: _____
_____
_____
_____

Re: **Patient Name:** _____
Date of Birth: _____
Social Security Number: _____
Address: _____
_____

Dates of Service: **ALL**

I expressly request that the designated records custodian of all covered entities under HIPAA identified above disclose full and complete: **psychotherapy notes as defined in 45 CFR 164.501, as amended, medical records, x-rays, billing/financial records, and/or pharmaceutical/ prescribed medication records** of any kind or type whatsoever concerning any and all medical and/or hospital treatment or prescribed medications.

You are further requested not to disclose such information to any insurance adjuster or any other person without written authority from me to do so. I hereby revoke all previous authorizations given for the release of medical information for any reason or purpose whatsoever. You full cooperation with my attorney is requested.

This shall constitute my sufficient Power of Attorney for obtaining such information, records, or other such reports or copies thereof.

Documents received pursuant to this authorization shall be utilized solely for the purpose of this litigation and any and all appeals thereof. At the conclusion of such period of time, any and all documents utilized in the litigation and/or appeals process shall be destroyed.

Information about diagnosis or treatment for alcohol/substance abuse and HIV/AIDS may be disclosed as follows: (check all that apply)

_x_ Yes, disclose HIV/AIDS information **OR** _____ No, disclose HIV/AIDS information

_x_Yes, disclose alcohol/drug abuse information **OR** ___No, disclose alcohol/drug abuse information

This protected health information is disclosed for the following purposes:

____ This disclosure is made at my request in compliance with 45 CFR 164.508(c)(1)(iv)

__x__ My personal injury/employment matter filed in: _____

____ Other (describe) _____

You are authorized to release the above records to my representative/attorney who has agreed to pay reasonable charges made by you to supply copies of such records.

Representative: Ty Hyderally, Esq.
Hyderally & Associates, P.C.
33 Plymouth Street, Suite 202
Montclair, NJ 07042
phone: (973) 509-8500
fax: (973) 509-8501

I acknowledge that I have the right to revoke this authorization, in writing, by sending written notification to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under HIPAA privacy rules.
I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrolment, or eligibility benefits on whether or not I sign the authorization, unless a condition set forth at 45 CFR 164.508(b)(4) applies.
Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization shall be in force and effect until:

_____ Date: _____
___x___ Event: (describe) _Termination of my litigation_____

I understand the nature of this authorization is to authorize the release of my medical records, psychotherapy notes, etc.

_____

Signature of Patient or Personal Representative
Dated: _____

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative=s Authority to Sign for Patient (Attach documents that show authority)

_____

Witness Signature
Dated: _____

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