HIPAA AUTHORIZATION FORM FOR RELEASE/REQUEST FOR RECORDS

PATIENT'S NAME (please print) _____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____

I hereby authorize release or disclosure of protected health information about me as described below:

1. The following specific person/class of person/facility is authorized to release or disclose information about me:

2. The specific information that should be disclosed is (please give dates of service if possible/type of films)

_____

Release information to: Tamburro Law Offices 16 West Main St., Marlton, NJ 08053 (856)906-2790

I request these records as part of ongoing investigation as the patient's attorney.

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED.

YES, DISCLOSE THIS INFORMATION: _____

NO, DO NOT DISCLOSE THIS INFORMATION: _____

3. I understand that the information released or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

4. I may revoke this authorization by notifying_____ writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

5. This Authorization shall remain in effect until _____ .

FEES FOR COPIES: Federal and state law permit a fee to be charged for the copying of patient records. This facility has contracted with Smart Document Solutions to make copies. Your copies will be mailed along with an invoice, which will provide you with several options to pay on the invoice.

_____ _____ _____

Signature of Patient:
(the person about whom the information relates)

Date:

SS#:

OR, if applicable

_____

Signature of Guardian if Patient is a Minor: