Authorization to Disclose Health Information

Patient name: _____ Health Record No.: _____

Date of Birth: _____ SSN: _____ Patient Acct. No.: _____

1. I authorize the use or disclosure of the above names individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

Provider name: _____

Provider address: _____

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

____ problem list ____ medication list ____ allergies ____ immunization record
____ most recent history & physical ____ most recent discharge summary
____ laboratory results date: _____ ____ x-rays date: _____
____consultation reports date: _____ ____ ENTIRE RECORD

____ Other: Any and all other records that may be created as a result of office visits, surgical procedures, diagnostic testing, etc., from the date of this release, including billing statements generated as a result of such treatment.

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 by the following individual or organization: ABRAMS LANDAU, Ltd., 797 Center Street, Herndon, VA 20170
For the purpose of personal injuries sustained in the _____ workers' comp accident.

6. I understand I have the right to revoke this authorization 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 the revocation will not apply to information that has already been released in response to this authorization. I understand 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 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 I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact (insert HMO director, privacy officer, or other office or individual's name or contact information).

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness