HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

TO: _____

I hereby authorize the protected health information for:

_____

(Patient's Last Name) (Patient's First Name) (Patient's Middle Name)

to be released as specified in this HIPAA compliant Authorization.

1. Description of Information to be Disclosed

For the dates of service: _____, I authorize the release of any and all of the following records and information pertaining to the above named individual's medical care, treatment, and physical and mental condition:

☐ Compete Medical Record (includes information regarding billing, insurance, referral documents and records from external institution, facilities and providers and outpatient records),

or the following individual records:

☐ Ambulance Records

☐ ER Intake/Triage Records

Emergency Room Record

☐ ER Discharge Summary

☐ ER Discharge Instructions

☐ Accreditation Forms

☐ Admission Records

☐ Advance Directives

☐ CPR/Code Sheets

☐ Consent Forms

☐ Patient Information Records

☐ Insurance/Financial Agreement Records

☐ Discharge Summary

☐ Transfer Summary

- ☐ History/Physical
- ☐ Physician Progress Notes
- ☐ Nursing Progress Notes
- ☐ Office Chart/Notes
- ☐ Consultations/Evaluations
- ☐ Physician Orders
- ☐ Post-Anesthesia Records
- ☐ Echocardiogram
- ☐ Echocardiogram Tapes
- ☐ EKG
- ☐ Cath. Films (on disk)
- ☐ Catheterization/Angiogram
- ☐ Labor Records
- ☐ Fetal Monitoring Strips
- ☐ Labs
- ☐ Radiology-X-Ray films (on disk) and reports
- ☐ Radiology-CT films (on disk) and reports
- ☐ Radiology – MRI films (on disk) and reports
- ☐ Radiology- Cholangiogram films (on disk) and reports
- ☐ Radiology-MRCP films (on disk) and reports
- ☐ Radiology-ERCP films (on disk) and reports
- ☐ Ultrasound reports and videos
- ☐ Pre-Operative Checklists
- ☐ Pre-Natal Procedures
- ☐ Diagnostic Testing
- ☐ Pre-Anesthesia Records
- ☐ Anesthesia Records

- ☐ Post-Anesthesia Records
- ☐ Procedure Notes
- ☐ Operative Reports and Records
- ☐ Intra-operative Reports
- ☐ Intra-operative photos and videos
- ☐ Delivery Records
- ☐ Fetal Monitoring Strips
- ☐ Resuscitation Records
- ☐ Transfusion Records
- ☐ Pathology Reports and Slides
- ☐ Autopsy Records
- ☐ Postpartum Records
- ☐ Nursery Records
- ☐ ICU Records
- ☐ PACU Records
- ☐ NICU Records
- ☐ Plans of Care
- ☐ Assessments
- ☐ Flow Sheets
- ☐ Controlled Substance Forms
- ☐ Vital Signs/Allergies
- ☐ Intake/Output Records
- ☐ Respiratory Care/Therapy Records
- ☐ Radiation Records
- ☐ Medicine Administration Records
- ☐ Medicine Reconciliation Forms
- ☐ Rehabilitation Records

- ☐ Psychiatry/psychology/social services records
- ☐ Pastoral Care Records
- ☐ Physical Therapy Records
- ☐ Occupational Therapy Records
- ☐ Discharge Planning
- ☐ Patient/Family Education
- ☐ Discharge Instructions
- ☐ Billing/Insurance Records
- ☐ Correspondence
- ☐ Outpatient Records
- ☐ Medical Records from External Institutions/Medical Providers
- ☐ Other_____

I recognize that the protected health information may include psychiatric information, drug and alcohol information and HIV information.

2. Entities Authorized to Disclose

I authorize any hospital, clinic or other medical facility, physician, nurse, physical or occupational therapist, chiropractor, psychiatrist, psychologist, medical practitioner, pharmacy, emergency medical service, basic life support service, advanced life support service, insurance company and any other person or entity licensed to create and/or maintain protected health information for the individual to disclose the individual's health information as described above. I authorize any third-party record retrieval agent to retrieve the protected information as describe above for the use of the authorized recipient.

3. Authorized Recipient

I authorize the individual's information to be disclosed to:

THE LAW OFFICES OF CHRISTOPHER J. RUSSO, JR.
207 West Main Street
Suite 1
Salisbury, MD 21803

4. Expiration Date

This authorization expires two years after the date signed.

5. Right to Revoke

I understand that I have the right to revoke this authorization at any time by notifying the authorized recipient and the medical record custodian in writing. The revocation would not be effective for any actions taken in reliance upon this authorization prior to the receipt of revocation.

6. Re-disclosure

I recognize that protected health information disclosed to the authorized recipient may no longer be protected by HIPAA or other federal laws.

7. Eligibility for Benefits

Treatment, payment, enrollment in a health plan, or eligibility for health insurance benefits may not be conditioned on my signing this authorization.

8. Facsimiles

A copy or facsimile of this authorization is as valid as the original.

9. My Right to a Copy

I hereby understand that I have a right to a copy of this fully executed authorization which I can obtain from the authorized recipient.

I have read and understand this authorization and authorize the disclosure of the protected information as described above.

Signed: _____ Individual's SSN: _____

Date: _____ Individual's DOB: _____

(Please complete the following section if the person signing this authorization is acting as the legal representative of the above-named individual.)

Relationship of Representative to Individual: _____

Authority of Representative to act on behalf of the individual: _____

_____