LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: SSN: D/O/B:

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

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

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ problem list
☐ medication list
☐ list of allergies
☐ laboratory results from (date) _____ to _____
☐ x-ray/imaging reports from (date) _____ to _____
☐ consultation reports from (doctors' names) _____
☑ entire record
☐ other _____
☐ immunization record
☐ most recent history and physical
☐ most recent discharge summary
☐ DO NOT RELEASE records regarding AIDS or HIV treatment or diagnosis if this box is checked.
☐ DO NOT RELEASE records regarding behavioral or mental health services, and treatment for alcohol and drug abuse if this box is checked.
☐ DO NOT RELEASE records regarding treatment for alcohol and drug abuse if this box is checked.

4. I understand that unless the appropriate box is checked above, 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 firm for purposes of litigation:

   _____

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 contest a claim under my policy.

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, or payment of 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. This authorization WILL AUTOMATICALLY EXPIRE: Upon the fulfillment of the above-stated purposes; or six months from the date of this authorization, whichever first occurs.

LIMITATIONS

1. This authorization DOES NOT ALLOW any doctor or other medical personnel who have treated or examined me to discuss my medical history with, be interviewed by, or prepare written reports for the bearer of this authorization.
2. **A photocopy of this authorization is NOT valid.**
3. **This authorization DOES NOT ALLOW the bearer to obtain original x-rays, tissue blocks, slides or pathology materials.**

Signature of Patient or Legal Representative _____ Date _____

If Signed by Legal Representative, Relationship to Patient _____