

AUTHORIZATION TO RELEASE INFORMATION

INCLUDING PROTECTED INFORMATION- PER HIPAA PRIVACY RULE 45 CFR§ 164.508 & California Civil Code §56.11

I authorize _____ to disclose to the Law Offices of Estey & Bomberger, and its employees, agents, copy services, legal representative, attorneys, medical examiner/evaluators, and to make available for review, inspection, and copying all protected health/medical information pertaining to:

Name: _____ Date of Birth: _____

Social Security No: _____

Address: _____

Telephone Number: _____

Specify the records to be disclosed:

- _____ Medical reports, records, charts, notes, letters, bills, liens & explanation of benefits;
- _____ X-rays, MRIs, CT scans, films, and reports;
- _____ Personnel, attendance, employment and wage records of employer or school;
- _____ Financial records, including, but not limited to tax records;
- _____ Police and ambulance/fire department records/ reports.

PURPOSE: This information will be used to assist the investigation, evaluation and pursuit of my legal rights. Complete medical records are necessary to accomplish this purpose.

DURATION: This authorization shall remain valid and in effect for the duration of the claims/case processing activity performed in connection with my claim/case for benefits or damages, however, this period shall not exceed three (3) years.

REDISCLASURE: I understand that the recipient may further disclose the specified information to others and that the health information may no longer be protected.

REVOICATION: This authorization is subject to revocation at any time. The request to revoke should be made in writing; it will be effective upon receipt except to the extent that the disclosing party or others have acted in reliance on this Authorization.

COPY FURNISHED: I have received a copy of this authorization. A photocopy of this original is to be treated as an original.

Authorized Signature

Date

Name

Relationship (If applicable)

_____ I consent to disclosure of all records related to drug/alcohol, psychiatric or HIV/AIDS conditions. I understand that such information cannot be released without my specific consent.

Authorized Signature

Date