

HIPPA AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

By signing this Authorization, I, hereby authorize _____
 (“provider”) to use or disclose certain medical information pertaining to _____
 (“patient”) as set forth below:

1. I authorize the entire medical record related to the patient to be used or disclosed as set forth in this Authorization.
2. I authorize this information to be disclosed to the attorneys with the following name and address:
GREENE & TISCHLER, P.A., 2503 Del Prado Blvd., Ste 402, Cape Coral, FL 33904.
Telephone: (239) 573-7400; Facsimile: (239) 573-7404.
3. I authorize this information to be disclosed to the above named attorney(s) for use in my legal representation.
4. I understand that I have the right to revoke this Authorization at any time in writing, except to the extent that the above referenced provider has already acted in reliance on the Authorization.
5. I can revoke this Authorization by providing a written revocation to the provider at the following address:
to the Attention: Privacy Officer/Records Custodian.
6. I understand that the provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.
7. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and that the information is no longer subject to applicable privacy laws.
8. This Authorization shall be effective for two (2) years following its execution or until I revoke it in writing.

AUTHORIZATION FROM PATIENT

Signature of Patient

Typed/Printed Name of Patient

Date

AUTHORIZATION FROM PERSON OTHER THAN PATIENT

Signature of Person other than Patient

Typed/Printed Name of Person other than Patient

Legal Relationship to Patient (Attach Documentation)

Date

Street Address/PO Box of Person making Authorization

City/State/Zip Code of Person Making Authorization

Telephone Number of Person Making Authorization