HIPAA COMPLAINT AUTHORIZATION TO RELEASE MEDICAL RECORDS/NOTES

Name of provider authorized to make the requested disclosure:

____

Patient Name: ____

Date of Birth: ____________________ Social Security No. ____________________

I authorize the disclosure of all psychiatric, psychological or other confidential records relating to my emotional or other psychiatric/psychological condition, including substance abuse (including drug and alcohol information) for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information, including the following:

1. **All billing records showing all charges, expenses, costs, and payments,**
2. **Original x-ray film,**
3. **Drug and alcohol abuse testing, evaluation, and treatment,**
4. **Mental health information consisting of but not limited to all notes, records, and reports of psychotherapy diagnoses, evaluation, and treatment.**

This authorization is given in compliance with 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived. I authorize you to release the protected health information to:

Law Offices of Cohen & Blitz, 23151 Moulton Pkwy., Laguna Hills, CA 92653

- The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.
- I acknowledge the right to revoke this authorization at any time. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected under 45 CFR 164.508.
- I acknowledge the right to inspect the material to be released.
- I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.
- Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein. This authorization expires two years from the date below.

Signature: ___________________________ Date: _________________

Attorney Signature: ___________________ Date: _________________