To: ANY DOCTOR, HOSPITAL OR MEDICAL PROVIDER AT ANY LOCATION

Health Care Provider

AUTHORIZATION *for* USE *or* DISCLOSURE of PROTECTED HEALTH INFORMATION Pursuant To THE HEALTH INSURANCE PORTABIITY AND ACCOUNTABILITY ACT OF 1996 145 C.F.R. 164.5081

Patient Name:

Address: _____

I consent to and authorize the above named Health Care Provider, and/or their duly designated billing or records agent to release to:

Calhoun Law, PC, 124 East Main St. Lincolnton, NC 28092
P.O. Box 695, Lincolnton, NC 28093-695

Medical Information including physician or nurses' notes/summaries and diagnostic results for the following periods:

The information will be used/disclosed for the following purposes: **LEGAL REPRESENTATION**

This will authorize **Calhoun Law, PC, 124 East Main St. Lincolnton, NC 28092** or its duly authorized representatives, to examine, reproduce, or otherwise copy in any manner, and to discuss orally or obtain oral and written reports thereon as they may request, any of the following:

1. Any and all hospital records, x-rays and reports thereof, laboratory reports and records, all tests and reports thereof, statements of charges, and any and all records pertaining to my hospitalization(s);
2. Any and all medical records, including patient's record cards, file jackets, x-rays and reports thereof, laboratory reports and records, all tests and reports thereof, statements of charges, and any and all records pertaining to my medical care;
3. All notes, correspondence, or records of any other natured made by my physician, nurses, or other persons concerning me, my condition, or my treatment;
4. All tissue blocks and/or tissue slides;
5. All pathology specimens of any nature;
6. All electron microscopy films and/or reports;
7. Any and all educational and/or vocational records, reports, transcripts or other papers;
8. Any and all lien/subrogation claims information for Medicare, Medicaid and third party insurers.

(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and/or HIV/AIDS, if applicable)

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. The covered entity may not prevent my ability to receive treatment, payments, enrollment or eligibility for benefits on whether the individual sign the Authorization when the prohibitions on conditioning of Authorizations apply. I may inspect or copy any information used/disclosed under this authorization to the extent allowed by law. I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the Health Care Provider. I further understand that I may not revoke this authorization to the extent that action has been taken in reliance on this authorization. Unless revoked this Authorization will not expire and will continue to be valid throughout the term of my representation by Calhoun Law, PC. **A copy of this signed Authorization is as effective and valid as the original for three (3) years from the date of its signature.**

This is the ___ day of ____, 2020.

_____ _____

Patient's Signature **Patient's Date of Birth**