THE LAW FIRM, CALHOUN LAW, P.C.

124 EAST MAIN STREET, LINCOLNTON, NC 28092

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HIPAA AUTHORIZATION FORM FOR RELEASE OF MEDICAL INFORMATION

Date: _______________ **PATIENT:** ____

D.O.B. _____________________ **SSN:** _____________________ **Incident Date:** _____________________

I hereby authorize use of disclosure of protected health information about me as described below from the following facility:

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- **Treatment dates from:** _____________________ **to** ______________________________
- **Purpose of Release:** ☐ Request of Individual ☐ Legal purposes including discussions and proceedings
- ☐ **All Medical Records** ☐ **All Itemized billing/ledger** ☐ **Other** ____________________________

1. I, the above identified Patient, or my legal representative, hereby request and authorize the firm of The Law Firm, Calhoun Law, P.C., 124 East Main Street, Lincolnton, NC 28092, to make the requested use or disclosure, and to receive disclosure of protected health insurance about me. I understand I have a right to receive a copy of this form upon request.
2. The specific information that should be disclosed is as follows: All records, reports, x-rays, abstracts, and excerpts of all records and any other information that you possess relating to the examination, diagnosis, prognosis, care and treatment, or opinions rendered, concerning any and all conditions that the above identified Patient had in the past, may have in the future. I authorize the use of a photo static reproduction thereof to the same extent as the original.
3. I authorize the release of information related to AIDS or HIV infections, psychiatric care and/or psychological assessments, or information related to treatment for alcohol and/or drug abuse.
4. I understand that the information used or disclosed may be subject to re-disclosure by the person, firm, or facility receiving it and would then no longer be protected.
5. I hereby revoke all previous authorizations given by me for the release of medical information for any reason or purpose whatsoever, and specifically request that no medical information of any nature be shown, discussed, or released to any party other than The Law Firm, Calhoun Law, P.C.
6. I understand I may revoke this authorization at any time by notifying The Law Firm, Calhoun Law, P.C., in writing of my desire to revoke it and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by the facility or practice. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
7. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me whether or not I sign the authorization, and that refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
8. I direct and authorize The Law Firm, Calhoun Law, P.C., to pay all unpaid medical bills of which they are aware incurred because of the injuries suffered in the above-referenced incident. Said payments shall be made prior to any distribution of proceeds to me and shall be made from any sums received by The Law Firm, Calhoun Law, P.C., on my behalf after attorney's fees and costs have been paid.
9. This authorization expires on ________________________________, or upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me.

______________________________ ______________________________________

Date Signature

_______________ I certify that I am the legal guardian of the above-identified Patient.

_______________ I hereby certify that I am the Administrator/Administratrix of the estate of the above identified and now deceased patient.

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Signature