PATIENT AUTHORIZATION FOR THE
RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
(HIPAA)

I,_____,

Date of Birth: _____, Social Security #_____, hereby authorize

_____

or its agents, employees and associates, to release the protected health information that is described below, to **The Law Office of Justin Ziegler ,** its agents and employees.

The protected health information released herein is specifically as follows:

_____

_____

I hereby acknowledge my rights as disclosed hereinafter and authorize the release of the records as outlined above:

This authorization expires on:_____. If no date is provided, this authorization expires in three years.

DATED this _____ day of _____, 2006___.

_____
Patient or Legal Representative

If executed by a legal representative, the representative's authority to act on the patient's behalf is: _____ (e.g. "As a parent,"or attorney, or as legal guardian").

The protected health information released herein is specified as follows: The complete medical record/chart of the above-named patient and all materials or information including, but not limited to, all medical records, hospital records, physicians' records, surgeons' records, consultation records, operative reports, physical therapy and other therapy records; x-rays, CT scans, MRI scans, PET scans and reports, ultrasounds, or other diagnostic studies; laboratory reports; patient information and history questionnaires; history and physical examination records; discharge summaries; progress notes, prescriptions and medication records; nurses' notes; psychotherapy and/or psychiatric records and notes; correspondence; consent for treatment; statements for services rendered; labor/delivery records and fetal monitor strips (if applicable); and/or any other materials (whether written or stored, created or maintained in any other form, including e-mail or facsimile transmissions relating or pertaining to this patient), including documents and records received from or that were created by another provider.

I understand that the information in the patient's health record may include information relating to sexually transmitted disease, acquired immunodificiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse.

A photostatic copy of this authorization shall be as valid as the original.

The purpose of this authorization and request is to obtain ALL medical information about the patient's physical condition, which may be relevant as it pertains to certain personal injury claims or litigation.

I hereby authorize my attorneys at **THE LAW OFFICE OF JUSTIN ZIEGLER** to speak to my healthcare professionals privately or to take testimony at deposition or trial as may be requested

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing by sending or presenting my written revocation to the Privacy Contact of the health care provider named above. I understand that the revocation of this authorization will not apply to the extent that the health care provider has taken action in reliance thereon; or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that a refusal to sign this form will not result in a denial of health care by the hospital or any other health care provider and that this release has not been coerced by a health care entity or any of its business associates.

I understand that once the patient's health information (PHI) is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, insurance companies, and even may become public record if filed with a court of law.

I understand that authorizing the disclosure of this health care information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I have the right to inspect and amend my medical records as provided in 45 CFR 164.526. I have the right to an accounting of the use and disclosure of my health information to any third party as provided in CFR 164.528. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of the patient's health information by the recipient, resulting in the health information no longer being protected by federal or state confidentiality rules.

Florida Statutes §395.3025 provides: (1) Any licenced facility shall upon written request, and only after discharge of the patient, furnish, in a timely manner, without delays for legal review, to any person admitted therein for care and treatment of treated thereat, or to any such person's guardian, curator, or **personal representative, or in the absence of one of those persons, to the next of kin of a decedent or the parent of a minor,** or to anyone designated by such person in writing , a true and correct copy of all patients records including X-rays, and insurance information concerning such person, which records are in the possession of the licensed facility, provided the person requesting such records agrees to pay a charge. **The exclusive charge for copies of patient records may include sales tax and actual postage, and except for nonpaper records which are subject to a charge not to exceed $2 as provided in s. 28.24(9)(c), may not exceed $1 per page, as provided in s. 28.24(8)(a). A fee of up to $1 may be charged for each year of records requested**. These charges shall apply to all records furnished, whether directly from the facility or from a copy service providing these services on behalf of the facility. However, a patient whose records are copied or searched for the purpose of continuing to receive medical care is not require to pay a charge for copying or for the search. The licensed facility shall further allow any such person to examine the original records in its possession, or microforms or other suitable reproductions of the records, upon such reasonable terms as shall be imposed to assure that the records will not be damaged, destroyed or altered."