AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____
Social Security Number: _____-_____-_____ Date of Birth:_____-_____-_____

I authorize the use or disclosure of above named individual's health information as described below:

1. The following individual or organization is authorized to make the disclosure: Name and Address:_____

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
   - ☐ problem list
   - ☐ medication list
   - ☐ list of allergies
   - ☐ immunization record
   - ☐ most recent history and physical
   - ☐ x-ray and imaging reports
   - ☐ laboratory results
   - ☐ most recent discharge summary
   - ☐ consultation reports
   - ☐ **entire record** (whether mental or physical
   - ☐ other _____

3. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, billing records, photographs, videotapes, drawings, included but not limited to, the date of my injury.

4. This information may be disclosed to and used by the following individual or organization: The Law Office of James Foster Andrews 709 Studewood, Houston, Texas 77007 . **To be used for the purpose of litigation and legal representation.**

5. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____, 200__. If I fail to specify an expiration date, event or condition, this authorization will expire in six months (180 days).

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my attorney, JAMES FOSTER ANDREWS, 709 Studewood, Houston, Texas 77007, 713-529-9033, 713-529-8605 (fax).

7. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness