AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

TO:_____

PATIENT'S NAME:

DATE OF BIRTH: SSN:

I hereby authorize use or disclosure of protected health information about me as described below:

1. _____is authorized to make the requested use or disclosure.

2. The following person or class of persons may receive disclosure of protected health information about me:

Thomas J. Dolina, Esquire
Dolina/Hobbs, LLC
82 West Washington Street, Suite 200, Hagerstown, Maryland 21740

3. The specific information that should be disclosed is my complete medical file, including but not limited to any and all reports, notes, diagnosis, analysis, billing statements, and any other record. This will also authorize you to speak with and disclose orally any information relating to the same.

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

5. 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 and present my written revocation to the health information management department. I understand that 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: _____.

6. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty (60) days. 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 that I may inspect or copy the information to be used or disclosed, as provided in C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact: _____.

7. The purpose for this request is litigation.

_____
Signature of patient or legal representative

Date: _____

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law and federal law 42 C.F.R., Part 2.