

Medical Authorization
In Accordance with 45 CFR Section 164.508(c) - HIPAA

Upon presentation of this authorization, or a photostatic copy thereof, you are requested to provide the records outlined below to **America First Legal Services, 325 N. Saint Paul Street, Suite 1900, Dallas, Texas 75201 (phone 800.497.7618 - fax 800.311.8300)** who is acting as an agent of my attorney.

Patient Information

Name _____ Social Security No. _____

Date of Birth _____ Account No. _____

Healthcare Provider _____

Dates of Service (Check One and Complete Dates of Service if Required)

Please provide a complete copy of my file for all dates of service

Please provide a complete copy of my file for service from _____ through _____

Records to be Released (45 CFR § 164.508(c)(1)(i)).

- | | | |
|--|---|---|
| <input type="checkbox"/> All Records | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Lab/Pathology Reports | <input type="checkbox"/> Radiology Reports/Images | <input type="checkbox"/> Other _____ |

The purpose of this request is for legal review or personal use (45 CFR § 164.508(c)(1)(iv)).

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I Understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

Date: _____ Signature: _____

Patient or Legally Authorized Representative

Printed Name of Patient or Legally Authorized Representative