HEALTH CARE ADVOCATES
INTERNATIONAL

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45CFR164.508

FROM:

TO: HEALTH CARE ADVOCATES INT'L,INC
2595 MAIN STREET STRATFORD,CT 06615
TEL: (203)345-0404
FAX: (203)908-4110

PATIENT NAME:_____

DOB:_____ **SS#:** _____

Current/Previous Doctor Name:* _____
Current/Previous Doctor Address:* _____
Current/Previous Doctor Phone Number:*_____
Current/Previous Doctor Fax Number: _____

I authorize and request the disclosure of all Protected Health Information (PHI) for the purpose of review and evaluation and continuity of care. I expressly request that the designated record custodian of _____, under HIPAA identified above,

(FILL IN FACILITY NAME),

disclose full and complete protected medical information including the following:

◯ All medical records, meaning every page in my records, including, but not limited to: all office notes, face sheets, history & physical, consultation notes, in-patient/out-patient and emergency room treatment; all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker/counselor notes, clinic records, treatment plans, admission records, discharge summaries; all requests for and reports of consultations, documents, correspondences, test results, statements, questionnaires/histories,
photographs, videotapes, telephone messages, and records received by all past medical providers; including:

(X) all physical, occupational rehab requests, consultations and progress notes;

(X) all disability, Medicaid/Medicare records including claim forms and records of denial of benefits;

(X) ALL LABORATORY RESULTS, including ALL HIV Resistance Testing (if applicable), and histology, cytology, pathology, immunohistochemistry records and specimens, radiology records and films including CT scans, MRIs, MRAs, EMG/NCS, bone scans/DEXA scans,

myelograms, and Electrocardiogram, Echocardiogram and cardiac catheterization results, videos/COs/films/reels/reports;

(X) and all pharmacy prescription records, including NDC numbers, drug information hand-outs/monographs.

I understand the information to be released or disclosed may include information related to sexually transmitted infections (STis), and/or Acquired Immunodeficiency Syndrome (AIDS) / Human Immunodeficiency Virus (HIV), and alcohol- and/or drug-related use/abuse. I authorize the release or disclosure of this type of information.
This Protected Health Information (PHI) is disclosed for the following purpose:

CONTINUITY OF CARE

This authorization is given in compliance with the Federal consent requirements for release of alcohol- or substance-abuse records of 42CFR2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above-mentioned records to the following medical personnel/facility and/or representatives of defendants in the above-entitled matter:

HEALTH CARE ADVOCATES INTERNATIONAL, INC.

_____

Name of Patient or Representative or Facility, Printed

_____

Representative Capacity (e.g. Attorney, Guardian, Agent, Records Requestor, etc.)

2595 MAIN STREET	STRATFORD, CT 06615
Street	*City ST Zip*
(203)345-0404	(203)908-4110
Telephone	*Fax Number*

I understand the following: (see CFR§164.508[c][2][i-iii])

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization;

b. The information released in response to this authorization may be re-disclosed toother parties; and

c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until one (1) year from date of execution at which time this authorization expires.

_____

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE DATE

(See 45CFR§164.508(c)(1)(vi)

NAME/RELATIONSHIP OF LEGALLY AUTHORIZED REPRESENTATIVE
(See 4SCFR§164.508(c)(l)(iv)

WITNESS SIGNATURE DATE