



# Jesse James Law Firm

**Serious Injuries | Serious Crimes | Serious Results**

## HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Patient's SSN

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
Name of Patient Name of Provider

to DISCUSS and RELEASE information specified from my medical and other confidential records covering the dates of service from \_\_\_\_\_ to \_\_\_\_\_, to the Jesse James Law Firm, 2515 First Avenue North, St. Petersburg, Florida 33713, or to any representative or investigator from said office. The purpose of the disclosure is for LEGAL purposes.

**Description of information to be used or disclosed:**

- |  |                            |                                 |               |
|--|----------------------------|---------------------------------|---------------|
| ___ Trip Sheet   | ___ Admission Summaries    | ___ Medications                 | ___ Diagnoses |
| ___ Nursing Records  | ___ ER Information         | ___ Discharge Summaries         | ___ Reports   |
| ___ Consultation Reports   | ___ Intake Sheet           | ___ MRI/X-ray/Imaging & Reports |               |
| ___ Laboratory Results   | ___ Physical Therapy Notes | ___ Office Notes                |               |
| ___ Reports  | ___ Questionnaires         | ___ Billing Ledger              |               |
| ___ All Information, Testing & Treatment for Mental, Behavioral Health or Psychiatric Care |                            |                                 |               |

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

**I understand that** I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed. Unless otherwise revoked, this Authorization expires \_\_\_\_\_ (insert applicable date or event). If no date is indicated, the Authorization will expire one (1) year from the date below.

\_\_\_\_\_  
Signature of Patient or Parent/Natural Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Relationship to Patient

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