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:

__ Medications __ Diagnoses

___ Trip Sheet ___ Admission Summaries ___ Discharge Summaries

___ Nursing Records ___ ER Information ___ 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

5107 Central Avenue
St. Petersburg, FL 33710
P: (727) 327-5700 | F: (888) 757-1624
JesseJames@JesseJamesLawFirm.com