

All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Patient's Name	Date of Birth	SSN
Address		Telephone No.

I authorize the use and disclosure of health information about me as described below: **

Facility Authorized to Release my Health Information:		
Agency or Individual(s) Authorized to Receive my Health Information:		
Health Information that may be used/disclosed is limited to the following: Durkin Law Offices, P.C.		
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Consultation(s)	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Operative Note(s)	<input type="checkbox"/> Imaging/X~ray
<input type="checkbox"/> Other (specify) _____		
Health Information that may be used / disclosed is limited to the following Treatment Dates: .		
Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s) ; (include Research or Marketing, if appropriate):		
<p>"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.</p> <p>I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit; encounter or hospitalization, or make copies thereof in accordance with the policies of this facility. Information may be subject to re-disclosure by recipient and no longer protected.</p> <p>I understand further use or disclosure of the authorized information by the above named agency / individual may not be accomplished without my further written authorization. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.</p> <p>This authorization will automatically <u>expire 60 days</u> after the date below (except as indicated above), unless an earlier: date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.</p> <p>Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.</p> <p>NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations..</p>		
Patient's Signature or Authorized Party	Date	Time 0 am 0 pm
Relationship to Patient	Interpreter, if utilized	
Witness' Signature	Expiration Date or Event	

Authorization to Use and Disclose Protected Health Information