

SPECIAL AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

NAME: _____

DOB : _____

ADDRESS: _____

SSA #: _____

I - IDENTIFICATION AND AUTHORIZATION

I, _____, give my consent to _____ to disclose information from my confidential protected health information, scholastic, employment, medical, psychological, alcohol and/or drug abuse records to MEDICAL LEGAL REPRODUCTIONS, INC. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and will no longer be protected under federal law.

II - SPECIAL PURPOSE

This authorization is given for the purpose of copying for verification, review and evaluation by _____, their firm employees and/or their designated representatives with respect to pending or future civil litigation for personal injury.

III - SPECIAL RECORDS REQUESTED

Any and all records as follows: () Hospital; () Medical; () Employment ; () Insurance; () Dental; () Government records; () Patient Billing; () to include X-rays/MRI/ Cat Scans; () _____

IV - STATEMENT OF OBLIGATION AND REVOCATION

I understand that my authorization shall remain valid from the date of my signature. I have been informed that I may revoke this authorization, except to the extent that action has been taken in reliance thereon, by written or oral communication. I have also been informed of my right, subject to section 7100.111.3 of the Mental Health Procedures Act, 1976, to inspect the information to be released and that all information will be handled confidentially, in compliance with the Federal Privacy Act (P.L. 93-575), the Federal Alcohol and Drug Abuse Act (P.L. 92-255) and HIPAA Regulations.

V - SIGNATURE OF PERSON AND WITNESS

DATE

SIGNATURE

WITNESS

VI - RELEASE OF HIV INFORMATION

I specifically request that information related to my HIV status be withheld from the above authorized Release by signing this document here for a second time. A general authorization for release of medical or other information is not sufficient for this purpose by the Confidentiality of HIV-Related Information Act (Act 45 P. S. & 7601 et seq).

SIGNATURE TO WITHHOLD HIV INFORMATION

VII - STATEMENT OF EXPIRATION

This consent shall expire in six months (or) on _____ .