AUTHORIZATION TO RELEASE HEALTH CARE RECORDS

I, _____, hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by Federal Privacy Regulations.

I specifically authorize each of my health care providers to release unto any attorney or legal assistant in the law firm of _____, or its designee, all pharmaceutical or medical records of every nature pertinent in any way to any medical treatment rendered on my behalf at any time in the past, including, but not limited to, the following:

1 All hospital records;
2 All progress reports, clinical reports and summaries;
3 Results of all laboratory tests, original x-rays, CAT scan results, MRI images or sonogram results and diagnostic studies, relating to the chest and/or abdominal cavity;
4 All pathology materials including blocks, slides and wet tissue (if available) relating to the chest cavity and/or abdominal cavity, that are not necessary to my care and treatment;
5 Records of prescribed medication and treatment;
6 All correspondence between any doctors or their administrative staffs, or the administrative staffs of all hospitals, clinics, or other medical treatment centers where I have been a patient or from whom I received medical care, and me or a representative of me;
7 All correspondence between any doctors or their administrative staffs, or the administrative staffs of all hospitals, clinics, or other medical treatment centers where I have been a patient or from whom I received medical care, and any insurance companies or their representatives concerning any claims made by me or on my behalf for medical treatment or for benefits of any nature including, but not limited to, disability benefits, social security benefits, and Veterans Administration benefits;
8 All statements rendered for medical services and supplies;
9 All notes, correspondence, or records of any nature made by any physicians, nurses, or any other persons concerning me, my condition, or my treatment.

This information is for use in connection with pending litigation in which I am involved.

I understand this authorization will expire two (2) years from the date entered below, unless sooner revoked in writing. In this regard, I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do so it will not have any effect on any actions taken before the revocation was received.

A photocopy of the signed original of this Authorization shall be sufficient and acceptable to all persons and entities from whom my records are requested, or from whom interviews are sought.

Date: _____ _____

Social Security Number: _____

Date of Birth: _____