AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Provider:

Patient Name:

Regarding:

Information to be Used or Disclosed:
I authorize any physician, hospital, health care provider, health facility, and governmental or private agency, including the Workmen's Compensation Commission, and each of them together with their respective employees and/or agents, to disclose my "protected health information" to Legal Counsel for Defendant(s), as specified in this Authorization and set forth in privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Rule").

I understand that my protected health information includes any and all medical records, medical opinions if in writing, original x-rays, papers, notes and histories, pathology, tissue samples, cytology, blocks, slides, or other pathology specimens, or any other documents, records or papers concerning any past medical history and/or treatment, examinations, periods of hospitalizations or confinement, diagnoses, or any other information pertaining to and concerning my physical or mental condition and treatment or billing/payment information relating thereto. I understand "protected health information" also includes records disclosed to my health care providers by health care providers and facilities who previously provided treatment to me. I understand "protected health information" may also include information and records protected under Federal Law (such as alcohol and drug abuse treatment information) and/or protected under State Law (such as mental health treatment or AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus). I specifically authorize the disclosure of any and all protected health information, opinions, records, medical records, medical history, consultation, prescription or treatment relating to my physical or mental health and relating to any referral, diagnosis or treatment for alcohol or drug use. I also specifically authorize the disclosure of any and all papers concerning any claim or claims which have been filed by me against any employer or employers before the Workmen's Compensation Commission, or any commission of any other state.

This authorization permits only the copying of any and all papers, records, etc., **with the exception of x-rays and tissue samples, which must be produced in original form.** Original x-rays are required because of the nature of the claim I am making. X-ray copies cannot be interpreted for pneumoconiosis or other certain conditions, and therefore copies are not effective. Copies may be maintained by the hospital or other organization if deemed necessary, but the original x-rays must be turned over when a request for them is accompanied by this authorization.

Discussions with healthcare providers must be limited to the obtaining of materials and the scheduling of depositions, hearings, and trials. However, such healthcare providers are authorized by me to disclose and explain my protected health information during depositions, hearings, trials or other proceedings in the above Lawsuit.

Person(s) Authorized to Make the Use or Disclosure:
Any physician, hospital, health care provider, health facility, institution and governmental or private agency, including the Workmen's Compensation Commission, which possesses any of my protected health information is authorized to make the uses and disclosures specified in this authorization.

Recipient(s) of Use or Disclosure:
My protected health information may be used by or disclosed to the attorneys, consultants, experts, employees and other agents hired or employed by Defendant(s) or its legal counsel, in connection with, or for purposes of, Defendant's(s) defense of the Lawsuit.

Purpose(s) of the Use or Disclosure:
The purpose of the use or disclosure is to provide my protected health information regarding my care and treatment, including information as to the claims and injuries I have asserted in the Lawsuit. I understand that production of my protected health information to the recipients is necessary to evaluate the claims and injuries I have asserted in the Lawsuit. I authorize the use of my protected health information in discovery, depositions, hearings, trials, and other proceedings in connection with the Lawsuit, and I understand such protected health information will be used only for purposes provided for herein. This authorization will expire at the close of litigation, including all appeals, for the Lawsuit.

I understand I may revoke this Authorization by submitting a written revocation to Legal Counsel for Defendant(s), who shall forward such revocation to those persons or facilities from whom my protected health information has been requested in connection with the Lawsuit. However, such revocation will not be effective with respect to any use or disclosure made in reliance on this Authorization before the person or entity making the disclosure received my revocation. I understand that health care providers and facilities cannot condition my treatment on whether or not I sign this Authorization.

I understand my protected health information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipients, in which case it might no longer be protected under the HIPAA Privacy Rule.

This authorization is continuing in nature and maintains full force and effect for use in obtaining my protected health information dated both before and after the date of this document. A photocopy of this authorization shall have the same force and effect as the original, and the parties authorized to use, disclose, or receive my protected health information hereunder may rely on it as if it were.

_____ _____
Print Patient Name Patient Social Security Number

_____ _____
Patient Signature Date of Signature

OR

_____ _____
Personal Representative of Patient Date of Signature

Basis of Personal Representative's authority to sign for patient: _____