AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
In compliance with HIPAA Reg. § 45 CFR 164.508

TO:

RE: Our Client:

DOB:

You are hereby authorized to release or discuss the protected health information in your possession concerning me, or the person whose representative I am, to: Vanacore Law Office at 19 Washington Street, Concord, NH 03301.

The records release should include: Emergency/Ambulance Transport Records, Emergency Room Records, History and Physical Physicians' Orders, Physicians' Progress Notes, Consultations, Operative / Recovery Records, Radiology Reports, EKG strips and reports, Graphic Charts, Laboratory Records, Nurses' Notes, Therapy Records, Admissions and Discharge Summaries, Office Records, Correspondence, copies of all itemized statements, bills, payment receipts or other financial records, and a report to my attorneys concerning my medical treatment, condition, or prognosis for the period of:

_____

Please see attached cover letter for dates being requested, as they often differ from the dates authorized by client.

I understand that this request also pertains to records regarding Drug and Alcohol Treatment, Mental Health Records, and Communicable Disease Records, including HIV and AIDS. This information is requested for the purpose of litigation. You are authorized to discuss with the Vanacore Law Office all matters concerning my medical treatment, condition, prognosis and the records which are being requested. Please do not discuss or disclose information to any person(s) other than Vanacore Law Office without written authorization from me. A photocopy of this Authorization shall be deemed the same as one bearing my original signature. I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations. (§ 45 CFR 164.508(c)(1)(vi)) I understand that I may revoke this authorization by notifying, in writing, you and Vanacore Law Office, Concord, New Hampshire, of my desire to revoke it. However, I understand that if I revoke this authorization it will not have any effect on actions taken by any covered entity that relies on it before I revoke it. (§ 45 CFR 164.508) I understand this authorization will expire within one year from the date of signature, unless otherwise specified.

Date: _____ Patient's Signature: _____