AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

TO: ____

PATIENT INFORMATION:

Patient Name: ____

Date of Birth: _________________ SS# :___________________

I, __________________________________, authorize and direct you to release my entire medical and billing file, including but not limited to all medical records, labs, billing ledger, physician orders, medications, etc., to:

RECIPIENT INFORMATION:

Name: LAW OFFICE OF CHAD A. BARR, P.A.
Address: 986 DOUGLAS AVE, SUITE 100, ALTAMONTE SPRINGS, FL 32714
Phone: 407-599-9036 FAX: 407-960-6247

SPECIFIC DOCUMENTS TO BE RELEASED:

( ) ALL Records
( ) History/Physical
( ) Labs
( ) Physician Orders
( ) Medications
( ) Face Sheet
( ) Operative Reports
( ) Radiology Reports
( ) Cardiology Reports
( ) Itemized Bills
( ) Discharge Summary
( ) Consultation
( ) Progress Notes
( ) Nurses Notes

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ______ (initials)

PURPOSE FOR INFORMATION:

( ) Continued Medical Care ( ) Insurance ( ) Personal ( ) Current Litigation

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

SIGNED: ____ Date: __________