HIPAA-COMPLIANT
AUTHORIZATION FOR RELEASE OF INFORMATION
(PURSUANT TO 45 C.F.R. 164.508)

TO:

REGARDING:

Healthcare Provider: _____ Patient: _____

Clinic/Hospital: _____ Patient Other Names: _____

Address: _____ Date of Birth: _____

City, State, Zip: _____ Social Security: _____

SPECIFIC REQUESTOR:

Attorney Glynis Adams McGinty
2238 E. Loop 820
Fort Worth, Texas 76112
(817) 446-6112 Phone
(817) 446-0524 Fax

INFORMATION TO BE RELEASED:

- ☐ All Medical Records in Entirety
- ☐ All Third-Party Medical Records
- ☐ All Medication/Pharmacy Records
- ☐ All Films, Scans, Photos & Videos
- ☐ All Pathology/Cytology Records
- ☐ All Doctor/Nurse Handwritten Notes
- ☐ All Admission/Discharge Records
- ☐ All Laboratory & Test Res
- ☐ All Radiology Records
- ☐ All Autopsy Records
- ☐ All Billing Records/Inform
- ☐ All Third-Party Billing Rec
- ☐ All Insurance Records/Info
- ☐ All Demographic Informati

PURPOSE OF DISCLOSURE: Legal review and Evaluation

Dates of Service from _____ **to** _____

Understandings:

1. I understand that this consent may be revoked in writing at any time, with the exception and to the extent that of information has already occurred prior to the receipt of revocation by the above-named provider.
2. If written revocation is not received, authorization will be considered valid for a period of time not to exceed from the date of signing. To initiate revocation of this authorization, direct all correspondence to the Requestor" above.
3. I understand that, pursuant to 42 C.F.R. 2.31, this consent is to include disclosure of:

   _____ Alcohol and/or Drug Abuse Records _____ Psychiatric Records

   _____ Sexually Transmitted Disease Information _____ HIV / AIDS Information
4. I understand that a photocopy of this authorization is to be considered valid as the original.
5. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosur recipient and may no longer be protected by Federal Law (45 C.F.R. 164.508).

_____ Dated: _____

Signature of Patient (or Personal Representative)

_____

Printed Name of Patient (or Personal Representative)

_____

Witness Signature Dated: _____

Authority to Sign for Patient (Documents Attached):

- ☐ Parent of Minor Child
- ☐ Power of Attorney
- ☐ Representative of Deceased's Estate
- ☐ Representative of Incapacitated Adult