AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulation, including HIPAA. I release the organization providing this information from any legal responsibility or liability for disclosure of this information to the extent indicated and authorized herein.

The following individual/organization is authorized to release the requested health information:

Name: _____

Dates of service being requested: From: _____ To: _____

The following is a list of the specific information being requested:

☒	Admission history and physical	☒	Lab reports	☒	Progress notes
☒	Anesthesiology records	☒	Medication records	☒	Radiology: X-ray, CT, MRI, PET, SPECT reports
☒	Consultation notes	☒	Nurses' notes		
☒	Discharge summary	☒	Office visit notes		
☒	Emergency Room notes and records	☒	Outpatient records		
		☒	Pathology reports	☒	Rehabilitation
		☒	Physicians' orders	☒	Surgery records
		☒	P.T and O.T. records	☒	Vital signs

I understand that the information in my health record may include information relating to treatment of alcohol or drug abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), and/or human immunodeficiency virus (HIV).

This information may be disclosed to and used by the following individual or organization:

Name: Bridgman Law Offices, PLLC **Address: 428 East 4th Street**
Phone: (704) 815-6055 **Suite 101**
Fax: (704) 271-9708 **Charlotte, NC 28202**

Purpose of disclosure: ☒ Legal review ☒ Insurance review ☐ Personal use ☐ Other

I understand that I have a right to revoke this authorization at any time by notifying the Medical Records Department of the providing organization in writing. 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 a right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary. I can refuse to sign this authorization. I understand the covered entity may not condition treatment, payment, or eligibility for benefits on if I sign this authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above indicated recipient without my signature.

I understand any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. **I understand that any photocopy of this document will be considered as valid as an original.** Unless otherwise revoked, this authorization will expire on the following date, event or condition: upon conclusion of representation by Bridgman & Serbin, PLLC. **If I fail to specify an expiration date, event or condition, this authorization will expire in twelve months.**

_____ **Date**: _____
(**Printed Name & Date of Birth of Patient)**

_____ **Witness**: _____
(Signature of Patient/Authorized Individual)

If Authorized Representative, please indicate relationship to patient: ☐ Spouse ☐ Parent ☐ Other

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The following individual/organization is authorized to release the requested health information:

Name: _____

Dates of service being requested: From: _____ To: _____

The following is a list of the specific information being requested:

- ☒ Admission history and physical
- ☒ Office visit notes
- ☒ Consultation notes
- ☒ Discharge summary
- ☒ Progress notes
- ☒ Radiology: X-ray, CT, MRI, PET, SPECT reports

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Name: _____

Dates of service being requested: From: _____ To: _____
The following is a list of the specific information being requested:

☒	Admission history and physicals	☒	Discharge Summaries	☒	Radiology: X-ray, CT, MRI, PET, SPECT reports

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