HIPAA AUTHORIZATION AND CONSENT FOR THE RELEASE OF RECORDS AND INFORMATION

TO: _____
_____
_____
_____

Name: _____
Social Security No:_____
Date of Birth: _____
Dates of Service: _____

1. This document represents my request, consent, and authorization for you to release my protected health information and other requested information/documents as set forth below to the **Law Offices of Dan A. Robin, Jr. Records should be sent to 2203 Pakenham Drive, Chalmette, Louisiana 70043, 504-271-9854, unless otherwise specified.**

____Any and all medical records, including but not limited to, ER records, history & physical records, discharge summary, outpatient records, office visits, operative reports, progress notes, nurses notes, physicians notes, physicians orders, flow sheets, anesthesia records, diagnostic reports, evaluations, consultations , correspondence, therapy, rehabilitation records, drugs or prescriptions, medications, laboratory reports, EKG tracings, fetal monitor tracings, electronic records, any treatment records or records related to treatment & care maintained on any computer, or any other documentation related to this individual. Note: This includes records you have received from other health care providers, unless re-disclosure is prohibited by the other health care provider

_____X-rays, films, MRIs, CT-scans, and reports

_____Workers Compensation Records

_____Medical Bills

_____School Records, including but not limited to, written evaluations, attendance and performance reports, report cards, notes, notices, correspondence, special school equipment requests and occupational, speech, language and physical therapy records and reports

_____Employment/Personnel Records

_____OTHER: _____

1. This document will also authorize you to speak to and disclose orally any information relating to my diagnosis, care, treatment, prognosis, injury and opinions to the above law firm or its employees and agents.

2. I understand that I may revoke this authorization by notifying Law Offices of Finckbeiner & Robin, An Association for the Practice of Law and said health care provider in writing of my desire to revoke this authorization. Revoking this authorization will not have any effect on actions that the health care provider took in reliance on the authorization before the health care provider received notice of the revocation. Information disclosed under this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations.

3. I understand that my ability to receive health care treatment from the health care provider will not be affected if I do not sign this form. However, without my signature, this request to release information described above will not be honored. The protected health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases (including HIV/AIDS) and/or genetic marker information. These records will be included in the information we will make available to the individuals or organizations I have identified above.

_____ _____ _____

PRINTED NAME **SIGNATURE** **DATE**

Note to Health Care Providers: This authorization is provided in compliance with HIPAA. Failure to forward the requested information may render a health care provider liable for damages.

A COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS AN ORIGINAL.
THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM THE DATE OF SIGNATURE.