AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(HIPAA Compliant)

Patient Name: _____

DOB: _____ Social Security No: _____

The following health provider is authorized to provided medical records and disclose patient identifiable health information:

NAME: _____ ADDRESS: _____

_____

_____

The above named health provider is authorized to discuss my medical treatment and health information with my attorneys, Standeffer Law, LLC. The above named health provider is NOT authorized to discuss or disclose my medical treatment or health information to any insurance company or individual without my express written authority.

The scope of the health information to be provided or disclosed is as follows:
Any and all information, including, but not limited to all medical records for all dates of service for all medical conditions and treatment from the above named health care provider, as well as all medical records for all dates of service for all medical conditions and treatment from other health care providers and facilities. All billing records regarding the referenced incident. All medical release authorizations, notes, memoranda, correspondence, claim forms, patient information sheet, reports and insurance documents regarding the referenced incident. The information authorized for release also may include drug / alcohol abuse treatment records health information related to mental health and information which may indicate the presence of a communicable disease which may include, but is not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea and Human Immunodeficiency Virus also known as Acquired Immune Deficiency Syndrome (AIDS).

The health information is authorized to be provided to:

Standeffer Law, LLC
P.O. Box 35
Anderson, South Carolina 29622

864-622-2014 (telephone)
864-964-0930(facsimile)

At my request, my attorneys are authorized to act on my behalf regarding all insurance and legal matters. I authorize Harbin & Burnett, LLP to request my medical records for the purpose of investigating potential claims which I may have which involve my health and medical care.

RIGHT OF REVOCATION: I have the right to revoke this release authorization at any time. The revocation must be in writing and be delivered to Standeffer Law, LLC.

PATIENT RIGHTS: I have the right to inspect or copy the information to be disclosed, to inspect and amend my medical records, and to an accounting of the use and disclosure of my health information to any third party, as provided in CFR 164.528. I understand that signing this authorization is voluntary.

RE-DISCLOSURE: I understand that there is a potential for authorized and unauthorized re-disclosure of the information and that the re-disclosed information may not be protected by federal confidentiality rules.

I understand that the release of Protected Health Information through this Authorization will not affect my treatment, payment, enrollment or eligibility of benefits.

I understand the information to be released may include records related to behavior health care and genetics.

EXPIRATION: Unless revoked in writing by me and provided to the above provider, this authorization will expire upon the termination of the representation by Standeffer Law, LLC.

PHOTOCOPIES OF THIS RELEASE ARE VALID AND MAY BE USED IN LIEU OF THE ORIGINAL.

DATE: _____ BY: _____