AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION
(HIPAA Compliant)

Client Name: _____ Date of Birth: _____

Social Security No: _____

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 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 sheets, reports and insurance documents regarding the referenced incident. The information authorized by release may also include drug/alcohol abuse treatment records, health information related to mental health and information which may indicate the presence of communicable diseases 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).

AUTHORIZATION: All current and future employees of **Standeffer Law, L.L.C.,** are authorized to view my medical records to pursue any legal matter for which the firm represents me.

The patient identifiable health information received pursuant to this disclosure authorization is **to be used for the following purpose(s):**

No-fault (PIP) insurance claims, liability claims, uninsured and underinsured motorist claims, workers' compensation claims, and all other insurance or legal matters related to my injuries or health condition.

DISCLOSURE: I authorized **Standeffer Law, L.L.C.** to disclose my medical information to any insurance company, expert, consultant, doctor, health care provider, attorney or law firm, or any other person or entity, to pursue any legal matter for which the firm represents me.

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, L.L.C.** The revocation will not apply to records and information that have already been provided.

EXPIRATION: Unless earlier revoked, this authorization will expire upon the termination of the representation by **Standeffer Law, L.L.C.** I understand that a complete copy of my file, including medical records, will be maintained by **Standeffer Law, L.L.C.**, pursuant to the South Carolina Rules of Ethics.

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 unauthorized re-disclosure of the information and that the re-disclosed information may not be protected by federal confidentiality rules.

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

DATE: _____ BY: _____

WITNESS: _____