<u>Authorization To Release Protected Health Care Information</u>

TO: ________________________________

____

____

____

I, ____ pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations. 45 CFR § 164.508, IC6-39-1-1 and IC 16-39-1-4, the provider listed above is hereby authorized to release to the Law Office of Mark Nicholson or any of its representatives *<u>all medical records, including but not limited to:</u>* office notes, history, physical consultation notes, discharge summaries, order and progress notes, laboratory results, nurses notes, emergency room records, operative records, in-patient records, films of x-rays, MRIs or PET scans, pharmacy and drug records, medical bills, health insurance and Medicaid or Medicare records, concerning any medical treatment that I have received from you at your institution, as well as all such records which you keep in the regular course of business are found in my medical records file. I hereby authorize release of all records regarding mental health, psychiatric, chemical dependency or HIV. A photostatic copy hereof shall be as valid as the original.

The purpose of this authorization and request is to permit my myself to obtain ALL medical information pertaining to my physical or mental condition. This authorization expires three, (3) years from the date of the signature. The aforementioned expiration date has not passed, as this matter is ongoing.

I hereby authorize attorneys of the Law Office of Mark Nicholson to speak to my healthcare professionals privately or to take testimony at deposition or trial as may be requested.

I have the right to revoke this authorization in writing by providing a signed, written notice of revocation to the health care provider listed above and to the Law Office of Mark Nicholson. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. Medical providers may not condition treatment or payment on whether the above-listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

Signature: ________________________________ Date of Signature: ________________________

Address: ________________________________ Date of Birth: ____________________________

Social Security No.: ________________________

9702 E. Washington St., STE 171, Indianapolis, IN 46229

<u>Authorization To Release Protected Health Care Information</u>

TO: ____

____

____

____

I, ____ pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations. 45 CFR § 164.508, IC6-39-1-1 and IC 16-39-1-4, the provider listed above is hereby authorized to release to the Law Office of Mark Nicholson or any of its representatives *<u>all medical records, including but</u> <u>not limited to:</u>* office notes, history, physical consultation notes, discharge summaries, order and progress notes, laboratory results, nurses notes, emergency room records, operative records, in-patient records, films of x-rays, MRIs or PET scans, pharmacy and drug records, medical bills, health insurance and Medicaid or Medicare records, concerning any medical treatment that I have received from you at your institution, as well as all such records which you keep in the regular course of business are found in my medical records file. I hereby authorize release of all records regarding mental health, psychiatric, chemical dependency or HIV. A photostatic copy hereof shall be as valid as the original.

The purpose of this authorization and request is to permit my myself to obtain ALL medical information pertaining to my physical or mental condition. This authorization expires three, (3) years from the date of the signature. The aforementioned expiration date has not passed, as this matter is ongoing.

I hereby authorize attorneys of the Law Office of Mark Nicholson to speak to my healthcare professionals privately or to take testimony at deposition or trial as may be requested.

I have the right to revoke this authorization in writing by providing a signed, written notice of revocation to the health care provider listed above and to the Law Office of Mark Nicholson. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. Medical providers may not condition treatment or payment on whether the above-listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

Signature: ____ Date of Signature: ______________________________

Address: ____ Date of Birth: __________________________________

Social Security No.: ______________________________

9702 E. Washington St., STE 171, Indianapolis, IN 46229