AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
[HIPPA Approved Form]

Patient Name: Health Record Number _____
Address:

Date of Birth: Social Security No.: **xxx-x_-____**

1. I authorize the use or disclosure of the above-named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

_____
_____
_____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- A complete copy of the Patient's entire chart for the past five (5) years, including but not limited to (1) admission and discharge summaries; (2) consultation reports; (3) physician's orders; (4) history and examination notes; (5) test results, including but not limited to, x-ray, MRI and CT scan reports; (6) lab results; (7) office visit notes; (8) referral letters; (9) psychiatric, drug and alcohol records; (10) prescription and medication lists; (11) nurses' notes; (12) progress notes; (13) surgical/operative reports and narratives; (14) physical therapy records; (15) social case worker records; (16) incident reports; and (17) sentinel event investigation reports.
- Detailed billing statements, including but not limited to: Identity of provider and charges, CPT and ICD-9 codes for the treatment, payments received, and write-offs for contractual agreements with health insurers.
- Any opinions or reports requested by the Patient's attorneys, **but no other person.**

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

Mark Nicholson
Law Office of Mark Nicholson
9702 E. Washington St., STE 171
Indianapolis, IN 46229

for the purpose of: Personal Injury Proceeding.

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. 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 the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: sixty (60) days from date of signing.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Provider's records custodian.

____ Date: _______________

, Patient

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Signature of Witness