AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION PURSUANT TO 45 CFR 164.508

PATIENT NAME: Test

DATE OF BIRTH: 01/01/1980

DATE OF INJURY: 08/01/2023

TO: ALL DOCTORS AND HOSPITALS (INCLUDING VETERANS ADMINISTRATION AND GOVERNMENT HOSPITALS) AND CHIROPRACTORS

You are hereby authorized to allow _________________, its agents, employees, associates, investigators, and attorneys, to examine, photostat, or photocopy the following records:

All medical records pertaining to the examination, treatment, or consultation of the patient in relation to injuries suffered solely as a result of the above-dated occurrence; including, but not limited to, billing records, appointment records, x-rays and reports, history, laboratory findings, admission and discharge reports, treatment records, diagnosis and prognosis records, nurses' and doctors' notes and all other medical reports.

This information requested herein will solely be used for the purpose of investigating and processing the above-dated claim of the above-referenced patient.

The information obtained shall, under no circumstances, be disclosed to any other person/entity which has no relation with the processing of the above-dated claim.

Information disclosed pursuant to this authorization may be re-disclosed by __________________, and will no longer be protected by federal privacy regulations.

_____________________, will provide a copy of this authorization to the above-referenced Patient at his / her request.

Patient understands that this authorization is voluntary. Patient may revoke this authorization upon written request, signed by the Patient or on his / her behalf and delivered to you, but it will not affect information disclosed before the receipt of the written request.

The entity disclosing such information may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization.

This Authorization is valid for two (2) years from the date below. Photocopies or electronic copies of this Authorization will be considered as valid as the original.

The Patient may inspect a copy of his/her protected health information to be used or disclosed under this Authorization.

The Patient understands that organizations and individuals such as physicians, hospitals and health plans are required by law to keep health information confidential. Patient further understands that if he/she has authorized the disclosure of health information to someone who is not legally required to keep it confidential and it may no longer be protected by state or federal confidentiality laws.

The patient has the right to receive a copy of this authorization pursuant to CFR 164.508.

DATED:	SIGNATURE:
Aug 1, 2023	TEST