

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION, PSYCHIATRIC RECORDS AND WAGE INFORMATION TO BIRNBERG & ASSOCIATES

TO: _____
[Name of physician, health care prof.; hospital; organization, etc.]

MEDICAL AND PSYCHIATRIC RECORDS

I authorize any physician, health care professional, therapist, health plan, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment or services to me or on my behalf ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to the firm of Birnberg & Associates, its employees, agents or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and or treatment of any mental illness, including psychiatric or psychological records, reports, treatment notes, prescription history and medications prescribed, any social worker records, and any records, reports or treatment notes related to the use of alcohol, drugs, and tobacco. This Authorization also includes all billings and billing statements for any of the medical and other services listed above, that have been incurred by the undersigned at any of the medical and other individuals, hospitals, clinics and other medical facilities listed above.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, therapist, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Birnberg & Associates may represent me in my claim(s) and conduct other legally permissible activities in my behalf.

WAGE RECORDS

I further authorize the release to Birnberg & Associates, its employees, agents or representatives, any and all employment, payroll and wage loss-related records, all personnel, employment and earnings records, including but not limited to insurance coverage records, claims records, accident information and sick leave records.

DURATION

This Authorization shall remain in force for a minimum of 24 months following the date of my signature below, or until earlier revoked in writing by me, or in the event that my legal case is concluded, whichever occurs first. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me. I also understand that any information that is disclosed pursuant to this Authorization is no longer covered by federal rules governing privacy and confidentiality of health information. A copy of this Authorization is as valid as the original.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I also understand that upon request I may see and copy the information described on this form, and that I will receive a copy of this Authorization after I sign it. _____ **(Initial)**

Signed Date

Name: _____

Address: _____

Telephone: (____) _____ Date of Birth: ____/____/____ SSAN: ____/____/____