RELEASE OF RECORDS AUTHORIZATION

TO: _____

ADDRESS: _____

PHONE NUMBER: _____

Permission for Release of Protected Health Information/Records - In accordance with HIPAA:

Right to revoke: You may revoke this authorization at any time except to the extent that the medical provider has relied on the authorization. To revoke this authorization, you must submit a written revocation to the address above, attention: Privacy Officer.

Re-disclosure. Health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by the federal privacy rule or another privacy law.

I specifically authorize disclosure of the following:

___ my entire medical record

___ mental health records

___ drug/alcohol abuse records

___ X-ray films for * _____

___ records associated with my visit/admission on _____

___ HIV/AIDS related information

___ MRI films for * _____

___ Operative Report for * _____

___ Other _____

*Identify body part, surgery, or date.

Each purpose of the authorized uses and disclosures - Please check below:

___ Attorney request

___ Litigation

Expiration of Authorization - You **must** provide an expiration date. If no date is provided, the authorization will expire sixty (60) days from the date of your signature.

ETTLE & VELTRI
ATTORNEYS AT LAW
3 East Market Street
York, PA 17401

(717) 854-4899

Permission for Release of Employment/Education Records

All employers/educational institutions who have information, files, and records about me are hereby authorized to give to release to the law office of Gettle & Veltri or their designated representatives, any and all requested information, and to permit such person to copy or photocopy, or to have copied or photocopied, any file, record, or report concerning my employment/education.

Permission for Release of Insurance Records

All insurance companies which have information, files, records or reports about me are hereby authorized to release to the law office of Gettle & Veltri, or their designated representatives, any and all requested information, and to permit such person to copy or photocopy, or have copied or photocopied, any record or report concerning such insurance coverage, benefits, or payments.

Information Relevant to All Authorizations

1. A photocopy of this Authorization form shall be as valid as the original.
2. My signature set forth below is intended to be effective as to all Authorizations set forth above.
3. This authorization REVOKES all prior authorizations.
4. I understand that I can revoke this authorization by providing a written revocation to the person/entity at the address above.

I have read and understand this authorization and authorize use and disclosure of health/employment/education/insurance information as described in this authorization about the undersigned person(s).

Date : _____ Name:_____

DOB:_____