# AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

**RE:** **DOB:**

I authorize (name of health care provider) _____
to use and/or disclose a copy of the specific health and medical information below to Petersen, Sage, Graves, Layman & Moe, P.A., or its representatives or agents, for litigation and investigation of litigation.

I specifically authorize the use and/or disclosure of the following health information and/or medical records, if such information and/or records exist:

_____ Please send the entire medical records (all information) to the above named recipient.

_____ All hospital records (including nursing records and progress notes)
_____ Transcribed hospital reports
_____ Medical records needed for continuity of care
_____ Most recent five-year history
_____ Emergency and urgent care records
_____ Pharmacy records
_____ Clinical office chart notes
_____ Dental Records
_____ Laboratory reports
_____ Pathology reports
_____ Diagnostic imaging reports
_____ Billing Statements
_____ X-ray, CT Scan and MRI films to third party when requested

_____ Other: _____
_____

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL

This authorization DOES NOT allow for the release of information relating to sexually transmitted disease, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse.

This authorization DOES allow the preparation of narrative reports, release of legal correspondence or direct communication with physicians or other medical providers.

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. Nevertheless, I do not authorize re-disclosure of medical records except for the specific purpose listed above.

I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
(If not signed by patient, print name of legal representative (A copy of this signed form will be provided to the patient.) Relationship to Patient