LAW OFFICE OF
WILLIAM R. ORR

PHONE: 916.927.2226
FAX: 916.927.2228
EMAIL: CONSULT@WROLAW.COM
WWW.WROLAW.COM
P.O. BOX 348019 SACRAMENTO, CA 95834

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION
A HIPAA COMPLIANT RELEASE

The below signed patient, parent, and/or the patient's personal or legal representative hereby requests and directs you by the authority of the confidentiality of the Medical information Act, Welfare and Institution Code Sections 5328 and 42 CRF 2.3 et seq., Health insurance Portability and Accountability act on 1996 (HIPAA) 45 C.F.F 164, to release the information described below to the patient's representative and the patient's attorney to receive this information pertaining to:

I hereby authorize: _____ (Name of physician or health care provider authorized to use or disclose information) to disclose to the Law office of William R. Orr

Records and information pertaining to: _____ (Applicant's Name)

AKA: _____

For the purpose of aiding the patient or patient's attorney in determining the nature and extent of a claim for injuries and disabilities and to establish the liability for benefits, expenses, compensation and damages.

This information is limited to the following type and amount of information:
(Indicate each record type that is applicable)

Yes	No	Records
		Any & all Medical Records for the last _____ years
		Consultation Records
		Progress Notes
		Laboratory, Pathology Reports from _____ to _____
		Radiology/Imaging Reports from _____ to _____
		Actual X-Rays, MRI's, CT Scans from _____ to _____
		Personnel & Wage Records
		Patient Billing Information
		Immunization Records
		Other

Initials/Consent_____

Disclosure Requiring Special Consent
My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis or treatment for: *(initial appropriate areas)*

Consent Area	Initials	Consent Area	Initials
HIV/AIDS Virus		Mental Health/Psychiatric Disorders	
Sexually Transmitted Diseases		Drug, Alcohol Abuse/Treatment	

LAW OFFICE OF
WILLIAM R. ORR

PHONE: 916.927.2226
FAX: 916.927.2228
EMAIL: CONSULT@WROLAW.COM
WWW.WROLAW.COM
P.O. BOX 348019 SACRAMENTO, CA 95834

Right to Revoke: I understand that I have a right to revoke the authorization at any time. I understand that my revocation must be in writing and present to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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:

Expiration: If a specific expiration or event is not provided, this authorization shall become effective immediately and shall remain in effect three years from the date signed and a copy of this authorization is as valid as the original, as original authorization is not required to be shown.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for and unauthorized re-disclosure by the recipient 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 Director or Health information. I understand I have a right to receive a copy of this authorization.

_____ Date_____
Patient's Name

_____ Date_____
(If signed by other than patient, indicate relationship)