KIRBYS LAW
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REDONDO BEACH, CALIFORNIA 90278-3312

Print Form

CONSENT TO RELEASE INFORMATION AND OBTAIN RECORDS {Health Insurance Portability and Accountability ACT (HIPAA) Privacy Regulations}

IMPORTANT: DO NO SIGN THIS FORM UNLESS YOU HAVE READ IT CAREFULLY AND UNDERSTAND ALL OF ITS PROVISIONS

To: _____

I : _____

CLIENT/CLAIMANT/PATIENT
Hereby grant permission to and authorize any and every physician; medical practitioner; hospital; clinic; health dispensary or facility; provider of health care; insurance or reinsurance company; employer; educational institution; governmental agency, whether it be Federal, State or Local; to allow these designated entities;

Kirby and Kirby, and or their designated copy agencies.

To review, inspect, copy and/or photocopy for disclosure regarding my Personal Injury Claim which arises from that accident/ incident or occurrence of _____ and all dates of treatment that relate to the accident/incident or occurrence as set forth above;

Health Information identifies you (the patient) by name, and includes other demographic information about you. Health information may include, but is not limited to medical records, x ray films, slides, tracings, trips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit, encounter or hospitalization, or make copies therefore in accordance with the policies of this facility.

Protected Health Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire 3 years after the date below (except as indicated above)_ unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage. NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability ACT (HIPAA) Privacy regulations.

Health Information that may be used/disclosed is limited to the following

■ Discharge Summary ■ Consultation(s) ■ Pathology Report ■ Lab

■ History & Physical ■ Operative Note(s) ■ Imaging/X-Ray ■ Entire Record

■ Other

Health Information that may be used/disclosed is limited to the following treatment:

Dates: _____

Exclusions: _____

The above information is being obtained to assist said authorized entities in evaluating my claim for benefits or damages.

This authorization is valid for three years from the date it is signed.

I understand that I am entitled to a copy of this authorization and acknowledge receipt of a copy thereof.

Dated:_____ _____

Signature of Patient, Client, Claimant

_____ _____

Subject's DOB.: **Subject's Social Security #**

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