HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: ____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

____
Street Address

____
City, State and Zip Code

RE: Patient Name: ______________________________

Date of Birth: ________________ Social Security Number: ____________________

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

My entire medical record, meaning every page in my record, including but not limited to: face sheets, progress notes, nurse's notes, social worker records, treatment plans, pharmacy/prescription records including NDC numbers and drug information handouts/monographs, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, records sent by other health care providers treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers for the period August 1, 1953, to present.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the purposes of compliance with the request of the named patient.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

Case 7:23-cv-00897-RJ Document 156-3 Filed 03/07/24 Page 1 of 2

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

U.S. Department of Justice
Civil Division, Torts Branch
Environmental Tort Litigation
C/O Litigation Management, Inc.
7976 Mayfield Road, Suite 150
Chesterland, OH 44026
Email: records@lmi-med.com
Fax: (440) 484-2055

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

______________________________________ ______________________

Signature of Patient or Legally Authorized Representative Date
(See 45 CFR § 164.508(c)(1)(vi))

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Name and Relationship of Legally Authorized Representative to Patient
(See 45 CFR §164.508(c)(1)(iv))

______________________________________ ______________________

Witness Signature Date