AUTHORIZATION TO RELEASE PROTECTED HEALTH CARE INFORMATION

TO:

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR § 164.508, the provider listed above is hereby authorized to release the law firm of **Pittenger Law Office, PLLC,** or any of their representatives, *all medical records, including but not limited to:* office notes, history, physical, consultation notes, discharge summaries, order and progress notes, laboratory results, nurses notes, emergency room records, operative records, in-patient records and films of x-rays, MRIs or PET scans, pharmacy and drug records, medical bills and health insurance Medicaid or Medicare records, concerning any medical treatment that I have received from you, at your institution, as well as all such records which you keep in the regular course of business are found in my medical records file. I hereby authorize release of all records regarding mental health, psychiatric (other than psychotherapy notes which must be requested by separate authorization), chemical dependency or HIV. A photostatic copy hereof shall be as valid as the original. I hereby authorize a free copy of my medical records pursuant to KRS 422.317 be sent, to the extent I have not already requested my one free copy.

The purpose of this authorization and request is to permit my attorney to obtain ALL medical information pertaining to my physical or mental condition. This authorization expires three (3) years from the date of the signature. The aforementioned expiration date has not passed, as this matter is ongoing.

I hereby authorize **Pittenger Law Office, PLLC,** to speak to my healthcare professionals privately or to take testimony at deposition or trial as may be requested.

I have the right to revoke this authorization in writing by providing a signed, written notice of revocation to the health care provider listed above and to **Pittenger Law Office, PLLC.** Medical providers may not condition treatment or payment on whether the above-listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

_____

PATIENT OR REPRESENTATIVE

(If personal representative, sign & describe his/her authority)

Social Security No.:_____

Date of Birth:_____

Date of Signature:_____