

**Authorization for Disclosure of Protected Health Information
Pursuant to HIPAA 45 C.F.R. 164.512**

I authorize the use/disclosure of health information as described below.

1. Person(s) or class of persons authorized to disclose the information:
Physicians, laboratories, clinics, pharmacies, pharmacy benefits managers, and all other medical facilities.
2. Person(s) or class of persons to whom the information may be disclosed:
Confidential Communications International, Ltd.

I understand that this may include information relating to acquired immunodeficiency syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus), psychiatric care, treatment for alcohol and/or drug abuse, and/or genetic testing.

3. Description of information to be disclosed: Medical records and reports, all related medical history, patient information and history forms, x-rays, x-ray reports, pathology, pathology reports, insurance records, health care providers' reports and consultations, prescriptions, off-work slips, therapy records, lab reports, notes, tests and billing records and statements, for a minimum of the last five (5) years.
4. The information will be used/disclosed for the following purposes: Use for discovery purposes and as evidence in a lawsuit.
5. I understand that the health information described above may be redisclosed and no longer protected by federal and state privacy regulations.
6. I understand that my healthcare or payment for healthcare will not be affected if I refuse to sign this authorization.
7. In consideration of the release of information by the entities listed in paragraph 1 in accordance with this request, I hereby release the entities listed in paragraph 1, their agents, servants and employees from any and all claims, demands, or liability of any kind, which might arise out of the release of such information and the effects thereof.

I understand that I have the right to revoke this authorization in writing at any time by sending written notice of revocation to the entities listed in paragraph 1. I understand that my revocation of this authorization will not be effective as to uses and/or disclosures of my health information that the persons(s) and/or organizations listed above have already made in reference to this authorization.

This authorization expires 180 days from the date signed.

Signature of patient or personal representative

If signed by personal representative,
State authority (e.g., Power of Attorney)

Printed name of patient

Date

Date of birth
of patient

Social Security Number
of patient

home zip
code

Former/alias/maiden name of patient