AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO:

Patient Name: Date of Birth:
Address: Social Security No.:

I, _____hereby authorize the above referenced provider, to disclose information as described below to ***The Mills Law Firm, LLP,*** *1520 Crescent Road, Suite 100, Clifton Park, New York 12065*

Information to be released:

/ / Progress Notes / / Radiology / /Diagnostic Tests /**X**/ Billing Records
/ / X-ray films / / Lab / /History & Physical / / EKGs
/ / Operative Procedure Report / / Discharge Summary / / Other: _____
/**X**/ **Complete medical record** (all items above, and also information regarding insurance, demographics, referral documents and records from other facilities and health care providers).

Covering the period(s) of treatment: any and all records in possession of facility/provider .
The purpose of this disclosure is: Litigation
This authorization is valid until: one year from date of signature below.

I understand that this consent is to include disclosure of:

/**X**/ Alcohol and/or drug abuse record /**X**/ Psychiatric records
/**X**/ Sexually transmitted disease information /**X**/ HIV/AIDS information

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization those services may be denied.

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested, to the Privacy Officer at the health care provider listed above. Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

This request is made in accordance with New York Public Health Law Sections 17 and 18, which limits the maximum allowable charge for copies to $.75 per page.

A copy of this authorization is to be considered as valid as the original.

_____ _____
Patient/Legally Authorized Representative Date

_____ Self
Printed Name Relationship to Patient

On this ___ day of _____, 20__, before me, the Subscriber, personally appeared _____ to me known and known to me to be the same person described in and who executed the foregoing instrument, and she/he duly acknowledged to me that she/ he executed the same.

_____

Note: This document must be made part of the patient's medical record. A copy of this document must be given to the patient or legally authorized representative.