MR&D

Mignini, Raab & Demuth, LLP

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (PURSUANT AND COMPLIANT WITH HIPAA)

Patient:_____

SSN:_____

DOB:_____

The purpose of the release and disclosure of this information is at the request of the individual. I, the undersigned, do hereby authorize_____

_____

or, any representative thereof, to furnish the law firm of :

Mignini, Raab & Demuth, LLP
606 Baltimore Avenue, Suite 100
Towson, MD 21204

or any representative thereof, with any ande all information which may be requested regarding my past, present, or future physical or mental condition and any treatment rendered to me during the period from _____up and to including_____.

I understand that I may specify a date of the expiration of this authorization, but that it shall expire by law, without my express revocation in writing, one year form the date written below. Revoking this authorization will not have any effect on actions that the health care provider took in reliance on the authorization before the health care provider received notice of the revocation. The information to be redisclosed may be protected by law. Information disclosed under this authorization may be redisclosed by the recipient and no longer protected by federal privacy

regulations. I understand that my ability to receive health care treatment from any health care provider will not be affected if I do not sign this form. However, without my signature, this request to release the information described above will not be honored. The protected health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases (including HIV/Aids) and/or genetic marker information. These records will be included in the information we will make available to the individual or organization I have identified above.

I further authorize Mignini, Raab & Demuth, LLP or any representative or physician appointed by that office to examine any x-ray pictures taken of me, and to examine and copy all or any part of my records which may relate to my condition or treatment for the period hereinabove set forth, specifically including any medical records that have been furnished by another by another health care provider.

Additionally, this Release allows for the release of any and all employment and/or educational records including, but not limited to; transcripts, personnel files, wage and salary information, date of hire/enrollment, date of termination and reason, formally requested by my attorney.

A photocopy of this Authorization shall constitute and be accepted as an original.

_____ _____

Patient/Employee or Representative (Explain Status Below) Date

If the patient is unable to authorize disclosure of this information, the reason is set forth below, and the supporting documentation is attached:

Reason: _____

*State basis for authority to give consent on patient's behalf: (a) Medical care Power of Attorney, guardianship, court order, or Letters of Administration (copy attached); (b) Relative or person authorized by law(explain relationship or legal authority): _____

_____

Note to Health Care Providers: This authorization is provided in compliance with HIPAA. Failure to forward the personal requested information may render a health care provider liable for damages.