

AUTHORIZATION TO RELEASE MEDICAL RECORDS OR INFORMATION

45CFR § 164.508 California Civil Code § 56.11 California Evidence Code § 1158

Date

Name:

AKA

Date of Birth

Date of Injury

Social Security

To:

Please list names of all hospitals, doctors, chiropractors, physical therapists, or other providers

Functions/Class All providers of health care, health care service plan, pharmaceutical company, or contractor that may disclose the medical information

I, the undersigned, authorize the above-named provider(s) of services to release to:

Name of law firm, attorney, insurance company or other persons requiring Personal Health Information.

Or their authorized agent Castle Copy Service, attorneys, doctors, or other classes of people that will evaluate my claim, injury, or potential law suit, all Personal Health Information (PHI) as described; medical records, files, charts, notations, reports, correspondence, photographs, films, any other documents in my files or charts(s) except as specifically excluded below:

or, only the following types of health information and /or only on the specified dates:

Dates(s) of Treatment: Type of Treatment:

The purpose of the disclosure, at the request of the individual, is to aid the individual and his or her attorney or insurance company in establishing the liability, nature and extent of a claim for injuries or disabilities and to establish benefits, expenses, compensation and damages.

Add here any other specific reason for the release of these records (PHI)

This authorization shall become effective immediately and shall remain in effect as long as is necessary for my attorney/claims examiner to complete the purposes stated, but shall expire 3 years from the date of my signature.

This consent is subject to revocation by the undersigned in writing at any time by sending revocation to the above requestor and to the providers listed above, except to the extent that action has been taken in reliance herein. If not earlier revoked, it shall terminate on the conclusion of my case without express revocation. If I revoke this authorization, it will not have any affect on actions taken by all parties in reliance of it before I revoked it.

I understand that the recipient may not lawfully further use or disclose the PHI unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

This is an informed consent for the release of my records. A photocopy of this signed authorization shall be deemed as valid as the original.

**AUTHORIZATION TO RELEASE ALCOHOL, DRUG ABUSE,
PSYCHIATRIC OR HIV MEDICAL RECORDS OR INFORMATION**

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I hereby also specifically consent to the release of any and all alcohol substance or drug abuse, records under the same conditions as outlined above.

Date _____ Signature _____

I hereby also specifically consent to the release of any and all psychiatric or mental health records or treatment information under the same conditions as outlined above.

Date _____ Signature _____

I hereby also specifically consent to the release of any and all HIV medical and HIV related information under the same conditions at outlined above.

Date _____ Signature _____

I certify that this medical release authorization was printed in 14-point type when I signed it. I have received a copy of this authorization.

Dated: _____ **SIGN HERE →** _____
(Signature)

(Name and relationship of party other than patient signing) (Patient name)

(Date of birth)