

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional)
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Provider's/Health Plan's Name:	Recipient's Name: William E. Hahn, P.A.		
Provider's/Health Plan's Address:	Address 1: 310 S. Fielding Ave.		
	City: Tampa	State: FL	Zip: 33606

This authorization will expire on the following: (Fill in the Date or the event but not both.)
 Date: _____ Event: Upon resolution of the pending litigation.

Purpose of disclosure: To be used during the pendency of litigation to evaluate claims I have made regarding my past, present and future medical care and treatment.

Description of information to be used or disclosed.

Is this request for psychotherapy/psychiatric Notes?	<input checked="" type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.
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Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical records <input checked="" type="checkbox"/> Doctors' notes, handwritten, dictated & typed <input checked="" type="checkbox"/> Nurses' notes, handwritten, dictated and typed		<input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Correspondence, including notes of telephone calls to and from the patient		<input checked="" type="checkbox"/> X-rays, MRIs, etc. <input checked="" type="checkbox"/> Insurance claim forms <input checked="" type="checkbox"/> Lab reports and results <input checked="" type="checkbox"/> Prescriptions <input checked="" type="checkbox"/> Itemized bill <input checked="" type="checkbox"/> UB-92 <input checked="" type="checkbox"/> Other: <input checked="" type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request for PHI for the purpose of marketing?

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? If yes, describe:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Print Name of Patient/Plan Member's Representative:	Relationship to Patient/Plan Member: