TODD E. McCURRY, P.A.

ATTORNEY AT LAW

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name:____ Date of Birth:_____________

Social Security:____________________________ Telephone Number:____________________

SPECIFIC INFORMATION NEEDED:

____Discharge Summary
____Prenatal Records
____Radiology Report(s)
____Information relating to the Treatment of Substance Abuse
____Photographs and other Images
_____Clinic Notes
_____Electrocardiogram
_____Operative Notes
____Other (describe) ________________________
_____HIV/AIDS Results
_____Lab Report(s)
_____Psych Records

PURPOSE: Disclosure of this information is needed for (Please Check all that Apply)
___________________Legal Proceeding Other________________________

AUTHORIZATION: I authorize and request __________________________ to release requested medical records and billing information to Todd E. McCurry, P.A., Attorney at Law concerning my treatment, to cover a period from ______________________________________.

I hereby authorize the use or disclosure of my personal health information as described above. I understand that I may refuse this Authorization and that this Authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then released information may no longer be protected by federal privacy regulations.

I understand that I may revoke this Authorization at anytime by notifying the Medical Records Department in writing and that ***this Authorization will expire one year from the date signed below***. This hereby releases the sender from all legal responsibility or liability of the release of information described in the above records. I understand that if I revoke my Authorization it will not have any effect on any actions ______________________________ took before it received the revocation.

I understand that medical records, laboratory records and reports, radiology reports, EMS reports, blood alcohol content reports, pharmacy records and reports, and all other handwritten notes, billing information may be sent electronically or via facsimile to another medical facility or physician's office involved in the care of the patient or responsible for any part of the patient's charges.

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PATIENT/CLIENT SIGNATURE

WITNESS:______________________________

DATE:_____/_______/______