Stephen B. Plott
ATTORNEYATLAW

Authorization to Use of Disclose Health Information Compliant with Health Insurance Portability and Accountability Act (HIPAA) Regulations

Patient Name: _____; DOB: _____; Social Security Number: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below.

2. The following individual(s) or organization(s) are authorized to make the disclosure:
   _____

3. The type of information to be used or disclosed is as follows: **COMPLETE MEDICAL RECORDS AND ITEMIZED BILLING STATEMENTS**.

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIC). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. The information identified above may be used or disclosed to the following individual(s) or organization(3): My attorney: **Stephen B. Plott, Law Office of Stephen B. Plott, 15221 Carrollton Blvd. Suite C, Carrollton, Virginia 23314**.

6. The information for which I am authorizing disclosure will be used for my personal injury litigation.

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire one year from the date on which it was signed.

9. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of patient or legal representative: _____ Date: _____

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