

HIPAA COMPLIANT AUTHORIZATION FORM

I, _____, hereby authorize use or disclosure of protected health information about me as described below:

1. The following specific persons or class of persons or facility is authorized to make the requested use or disclosure:

2. The following person or class of persons may receive disclosure of protected health care information about me: My attorney, Robert M. Mansour at the Law Office of Robert M. Mansour, 28212 Kelly Johnson Parkway, Suite 110, Valencia, California 91355 (800-799-7449) or my attorney's copy service, ASAP Attorney Service.

3. The specific information that may be disclosed is: All medical, psychiatric, chiropractic, hospital, therapy, imaging and other medical and/or billing records pertaining to my physical and mental health.

4. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

5. The purpose of releasing this information is for my attorneys to pursue a personal injury claim.

6. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.

7. I may revoke this authorization by notifying the Law Office of Robert M. Mansour in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand my attorney will provide medical information received pursuant to this authorization to insurance companies, their representatives, and/or attorneys relating only to the incident claim which is being handled by my attorney.

8. This authorization expires on the later date of two (2) years from the date of this authorization OR upon termination of representation by the attorney.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature: **X** _____ Date: **X** _____

Printed Name: **X** _____

Social Security Number: **X** _____ Date of Birth: **X** _____

OR IF APPLICABLE:

Signature of Guardian or Personal Representative Date: _____

A copy of this signed and dated form must be given to the individual or person signing on the individual's behalf.