LCS Job No.

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LCSrecordretrieval.com

HIPAA AND 42 CFR PART 2 COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. _____ _____ _____
PATIENT'S NAME **SOCIAL SECURITY NUMBER** **DATE OF BIRTH**

2. I, the undersigned, authorize the following specific entity, any parent company, and any other health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf to release any and all information requested by the accompanying subpoena or letter, to **LCS Record Retrieval (Legal Copy Services, Inc.)**

Provider: _____

_____

A description of the medical information to be released:

Any and all medical records, billing records, and films from birth to present.

3. I understand that unless I expressly direct otherwise:

a) the custodian will make the medical or other information reasonably available for inspection and copying, or,
b) the custodian will deliver to the requesting party the original information or a true exact copy of the original information accompanied by a signed copy of the provided certificate.

I understand that medical or other information may include records, if any, on alcohol, mental health, substance abuse, psychology, social work, information about HIV, AIDS, ARC, and any other communicable disease. This request for records includes records protected under the regulations of 42 Code of Federal Regulations, Part 2, if any.

4. This authorization is valid for thirty-six months. A copy of this authorization shall be considered as effective as the original.

5. This authorization is signed to make medical or other information regarding me available to the other party(ies) to the lawsuit for their use in any stage of the lawsuit. The medical or other information covered by this release is relevant because my mental or physical condition is in controversy in the lawsuit.

6. I understand that I may revoke this authorization, except to the extent action has already been taken in reliance upon this authorization, at any time by sending a written revocation to the doctor, hospital, or other custodian of medical or other information.

7. I understand that the recipient of the information provided may make further disclosure of this information that may not be subject to the protections set forth in 45 CFR Parts 160 through 164, including, but not limited to 164.512(e). I understand that my continued or future treatment by or payment to the Releasing Party is not conditioned upon my providing or signing this authorization.

8. By signing this form, I am confirming that it accurately reflects my wishes and have kept a copy of this form for my records.

_____
DATE

_____ _____
SIGNATURE **ADDRESS**

_____ _____
NAME (type or print) If signing as Personal Representative, please state under what authority you are acting. **CITY, STATE, ZIP**