HIPPA-CONFORMING AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize ____ and its related entities to use and/or disclose my protected health information for the exclusive use of my attorney Jon Katz, P.C, or any associate or representative thereof, 10509 Judicial Dr., Suite 101, Fairfax, Va. 22030, 703-383-1100. Disclosure to any other person or institution is explicitly forbidden. The information I authorize to be disclosed concerns all services rendered to me or information related to me including all reports, records, notes, bills, or writings of any kind whatsoever.

I understand that I have the right to inspect or receive a copy of the information I am consenting to release within the established polices of the aforementioned agency and its related entities.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that I may revoke this authorization at any time in writing. I understand that under some circumstances, I may not be able to revoke this authorization.

I understand that by authorizing the disclosure of protected health information, the recipient may further disclose this information, and Federal law will no longer protect it.

Patient Name: _______________________________ Birth date: __/___/___

Address: ____

Phone: _____________________ Social Security No.:____________________

Medical Record No.:_____________________ Service Dates: ___/____/____

____
Printed Name of Patient or Patient's Representative

________________________ __________________
Signature Date

This authorization will expire: ___/____/_____

This form is designed to comply with 45 CFR § 164.508