

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Patient Name	Date of Birth	Social Security Number
Patient Address		

1. I authorize the disclosure of the above named individual's health information as described below. This information may be disclosed to and used for **legal representation** by:

**TiMedLaw Firm, PA, 28870 US Hwy 19 N #300, Clearwater, FL 33761, 727 346 6489**

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

3. Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that: I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524; any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIM director, privacy officer, or other office or individual.

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

5. The following individual or organization is authorized to make the disclosure:

\_\_\_\_\_

\_\_\_\_\_

6. The type and amount of information to be disclosed is:

- Entire Records     Most Recent History And Physical and Discharge Summary
- Abstract (H&P, DC Summary, Consults, Path reports) for     All or From: \_\_\_\_\_ To \_\_\_\_\_
- Laboratory Results     All or From: \_\_\_\_\_ To \_\_\_\_\_
- X-Ray And Imaging Reports     All or From: \_\_\_\_\_ To \_\_\_\_\_
- Actual X-Rays And Imaging **preferably on CD-ROM**     All or From: \_\_\_\_\_ To \_\_\_\_\_
- Consultation Reports     All or From: \_\_\_\_\_ To \_\_\_\_\_
- Other \_\_\_\_\_     All or From: \_\_\_\_\_ To \_\_\_\_\_
- The health care provider may discuss my medical conditions, history and records with Devesh Tiwary, MD, JD

7. Include \_\_\_\_\_ Alcohol/Drug Treatment; \_\_\_\_\_ Mental Health Records; \_\_\_\_\_ HIV Records ; indicate by initialing above.

8. Unless otherwise revoked, this authorization will expire on: \_\_\_\_\_.

**If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months.**

9. My questions about this form have been answered and I have been provided with a copy of this form.

Patient or Legal Representative	Date	(if not patient, then relationship to patient) and authority to sign on behalf of patient