ADVANCED Diagnostic Group

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME:_____

LAST 4 OF SSN: _____ DOB: _____/_____/_____

By signing this Authorization Form, I (Patient or Personal Representative of the Patient) understand that I am agreeing to the disclosure of my / the Patient's health information. The health care provider named below will not condition providing treatment to me / the Patient on my execution of this Authorization Form.

I hereby authorize _____ to release my/ the Patient's health information, including but not limited to, medical and billing records, insurance information, progress notes, flow sheets, medication records, test results including HIV testing, physician orders, consultation records, diagnostic test results and films, videotapes, photographs, notes, call records, pharmacy records, psychiatric and counseling records, substance abuse records (including counseling), records pertaining to sexually transmitted diseases, and any other information contained in a designated record sent to:

NAME: _____

ADDRESS:_____APT/UNIT/SUITE_____

CITY_____STATE_____ZIP_____

The purpose for the disclosure is to respond to litigation in which I / the Patient am a party. This Authorization expires on the date that the underlying litigation is terminated by any means. This Authorization may be revoked by me at any time upon my written request unless the requested information has already been disclosed.

I am aware that any information that is disclosed to a third party pursuant to this Authorization may be subject to redisclosure and no longer protected by policies and applicable law.

_____ _____/_____/_____

Signature of Patient or Personal Representative Date

_____

If Personal Representative, state the nature of the authority to act for the Patient

Revised Dec 2014