HIPAA Compliant Authorization to Release Protected Health Information

To: _____

_____

_____

Please send records to:
XL Record Service
PO Box 153736
Lufkin, TX 75915

DOS:

Patient's Name:

1. To all physicians, health care providers, hospitals, clinics, and institutions that have provided treatment to, or for the benefit of, the above named patient.

2. Upon presentation of this authorization, or a photostatic copy, you are authorized and requested to furnish to _____ and/or XL Record Service or their representative, or any persons designated by them, any and all items, **subject to the limitations of the scope above**, requested by them relating to the treatment or care provided by you, your agents and employees, to the above named patient, which may include all records; reports; correspondence; notes; consultations; imaging films (including x-rays, sonograms, CT and MRI scans); monitor strips; billing statements; photographs, slides, records provided to your office from other health care providers, written prescriptions, medication administrative records, records showing NDC#'s for medications administered; or other information in any format pertaining to the treatment provided to the patient, for any and all injuries, illnesses and/or conditions, including drug/alcohol/mental health/**communicable and noncommunicable diseases and/or HIV/AIDS** testing and treatment.

3. I am requesting the release of the above-referenced information so that the records can be reviewed for legal purposes. I understand that I have a right to receive a copy of this authorization.

4. I retain the right to revoke this authorization at any time before it expires, which shall automatically occur one hundred eighty (180) days from the date of my signature, unless otherwise stated by me. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification of revocation to the physicians, health care providers, hospitals, clinics, and institutions. I understand that a revocation is not effective to the extent that disclosure of information has already occurred prior to receipt of the revocation.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand I have the right to refuse to sign this authorization and that treatment, payment for treatment, or enrollment of eligibility for benefits cannot be conditioned on my signing this authorization. I understand that I get a copy of this authorization. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

6. It is requested that you preserve the confidentiality of the physician/patient relationship and not discuss the relationship with any individuals, unless I or a representative of the above-referenced law firm are present and that you not release records to anyone other than the above referenced law firm, or any persons designated by them, without a valid authorization from me.

7. I request the medical records/bills/films be provided to XL Record Service via CD/email/download or other electronic means pursuant to the HITECH Act and any and all applicable state laws and regulations.

Dated this: _____ day of _____ , 20 _____

Signature: _____

Signer's Printed Name: _____

Relationship to Patient: _____

Patient's D.O.B.: _____ Patient's S.S.N.: _____