



LINGENBRINK
L A W

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize use or disclosure of protected health information about me as described below:

Information to be released from:

PROVIDER: _____

Information to be released to:

Lingenbrink Law, PS, Attorneys at Law, and/or any associates of said attorney at the address listed above.

Information to be released:

All medical records and billing statements, including all clinical or hospital records in full. This includes but is not limited to: X-rays, diagnostic testing of any nature, laboratory tests, correspondence, notes, written records, or written documents of any nature.

Purpose for which disclosure is being made:

Attorney

Insurance

Doctor

Personal

Patient Authorization: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. *I give my specific authorization for these records to be released.*

My Rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I may revoke this authorization in writing. However, I understand that any action has been taken in reliance thereof cannot be reversed and my revocation will not affect those actions; and unless earlier revoked, this authorization will remain valid for twenty-four (24) months from the date of my signature below.

Signature

Date

Date of Birth

Social Security Number