AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

(HIPAA ' CFR 164.508)

Name: _____ **To:**_____

Address:_____ _____

_____ _____

SSN: _____

DOB: _____ **Dates of Treatment:**_____

My signature below authorizes you to release all protected information specified below in your possession concerning the patient designated above or to:

Attorney name and address: Nye & Associates, PLLC, 3975 W. Federal Hwy., Ste. 1, Roscommon, MI 48653

X Copies of all charts, records, memos, correspondence, discharge summaries, admission records, operative notes, operative reports, anesthesia records, consultation requisitions and reports, physicians' orders, progress notes, nurses' notes, medical records, laboratory reports, pharmacy reports and records, therapy reports and notes, imaging requisitions and reports, tracings, pathology reports, and any other medical or treatment information.

X Copies of all monitoring tracings, records, and reports including EKGs, EEGs' echo cardiograms, oximeters and other monitor and test records.

___ Copies of itemized statements, bills, payment receipts and other 3rd party payer billings, payments and other financial records.

X Your report to my attorney about my diagnosis, condition, treatment or prognosis.

X Other:_____

I understand that once this information is disclosed to my attorneys it may be subject to re-disclosure by them and no longer subject to federal privacy protections of 45 CFR 164-508. (For SSA Claim of Appeal)

I understand that I may revoke this authorization in writing at any time by notifying you and (name of attorney) in writing of my intent and desire to revoke it. I further understand that my written revocation will only be effective as of the date it is executed and will not have any effect on actions taken by any covered entity that relied on it before my revocation. [' 45 CFR 164.508] (Expires 1 year from below date)

This authorization is initiated Aat the request of the individual@. You are authorized to discuss with my attorneys ONLY all matters concerning my medical treatment, diagnosis, condition and prognosis and the information requested Please do not discuss or disclose information subject to this authorization with any persons other than the attorneys designated above without separate written authorization from me.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining authorization. A photocopy, facsimile, or digital representation of this authorization shall be deemed valid and of the same effect as the original bearing my original signature.

Dated:

_____
Patient

STATE OF MICHIGAN)
COUNTY OF ROSCOMMON) ss

The foregoing instrument was acknowledged before me the _____ day of _____, 20__ by _____.

_____
- Notary Public
Crawford County, State of Michigan
My Commission Expires: