HIPAA AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: _____

Mediserv Medical Information Services, Ltd.
Custodian of Records
PO Box 8549
Fort Worth TX 76124

RE: PATIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

DATE OF TREATMENT: _____

FACILITY: _____

CITY: _____STATE: _____

I authorize and request the disclosure of all protected health information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period below:

FROM: _____

TO: _____

If the date of service occurred prior to January 1, 2009, you must include the billing account statement number(s).

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS, or human immunodeficiency virus (HIV), and alcohol and drug abuse). I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purpose(s):

_____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 23.31, the restrictions of which have been specifically considered and expressly waived.

Using Acrobat or Acrobat Reader, please complete the form above, save, print and return to:
Mediserv Medical Information Services, Ltd., Custodian of Records, PO Box 8549, Fort Worth TX 76124

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The undersigned, being either the duly authorized representative of the patient identified above, hereby authorizes Mediserv Medical Information Services, Ltd. to release the above-identified records to the undersigned:

NAME OF REPRESENTATIVE: _____

REPRESENTATIVE CAPACITY:
(attorney, records requestor, agent, etc.):_____

MAILING ADDRESS: _____

CITY:_____

STATE: _____ ZIP: _____

I understand the following: [See CFR 164.508(c) (2)(i-iii)]

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

b. The information release in response to this authorization may be re-disclosed to other parties.

c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

[See 45 CFR 164.508(c)(1)(VI)]

Patient
Signature _____ DATE:_____

If the patient is a minor, please have the legally authorized representative sign above and fill out the lines below. If necessary, provide a POA.

Printed Name and Relationship _____

Witness
Signature _____ DATE:_____

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