HIPAA AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Facility: _____
_____
_____
_____

I, _____, hereby sign this authorization and permit the above named facility to disclose and provide the following protected health information about me to Inman Kaminow, P.C. (and/or Bill Acquisition):

1. This authorization concerns the following specific medical information about me:

All invoices for any and all services (including but not limited to itemized billing); medical records including all patient intake forms, information forms, prescription sheets, personal notes and all reports; x-ray films and x-ray reports; physician's orders and physician's notes; nurse's notes; in-patient records and out-patient records; emergency room records; operative reports; medication records, blood tests; urine tests; results of radiographic or other diagnostic tests; myelograms; CT scan films and reports; EMG and NVC records; EKG records; MRI films and reports; including any and all physical therapy records from the Physical Medicine Department; any and all x-rays from the Radiology Department; any and all records of treating, consulting or examining physicians, made by you, at your request, or any records which you have seen or consulted, and any and all other reports or records in your possession concerning the care and treatment rendered to me on any and all dates.

2. The purpose of the requested use and/or disclosure is within the context of a legal matter.

3. I understand that I have the right to revoke this authorization at any time. I understand my revocation must be in writing and given to the medical records department. I understand the revocation will not apply to information that has already been released in reliance on my authorization. I understand the revocation will not apply to my insurance company when the law permits my insurer the right to contest a claim under my coverage.

4. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, to receive payment or eligibility for benefits unless allowed by law.

5.I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to privacy protection provided by law.

Please send my records requested above to: **Inman Kaminow, P.C., 9200 Corporate Blvd. Suite 480, Rockville, Maryland 20850** or any representative thereof.

A photostatic copy of this authorization shall be considered as valid as the original.

_____ _____

Witness Signature

Patient Name: _____

Date: _____

Date of Birth:_____

Last 4 Digits of SSN: _____

This authorization expires on: _____