MEDICAL RELEASE -HIPAA Compliant for release of records and information re: Social Security Clients of Diane K. Bross, PC.

Patient Name: _____ DOB_____

Health Provider:_____
(Please leave blank)

The above named health provider is further authorized to discuss my medical treatment and health information with my attorney, Diane K. Bross, PC and its employees. This release does NOT authorize the above named health provider to DISCUSS my medical treatment or health information with employees or adjustors of any INSURANCE COMPANY.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining the authorization.

The SCOPE of the health information to be provided or disclosed is as follows:

- All records for all dates of service for any health care conditions and treatment, including psychiatric care and/or psychological counseling in any facility or therapy office, and psychotherapy notes which may include any discussion of drug or alcohol use from the above named health care provider, as well as all records for all dates of service for any health care/mental health conditions and treatment from OTHER health care providers and facilities that are in the possession of the above named health care provider. This includes information that may be protected by State and/or Federal law; e.g., drug and/or alcohol abuse protected by 42 CFR, Part 2.

- All medical release authorizations, correspondence, claim forms, reports, notes, memoranda, and other insurance documents in your possession regarding the referenced patient and/or illness or injury.

The patient identifiable information received pursuant to this release authorization is to be used for the following purposes: Social Security Disability claims and claims that involve my health conditions and/or injuries.

RIGHT OF REVOCATION: I have the right to revoke this release authorization at any time. The revocation must be in writing and be delivered to Diane K. Bross, PC. The revocation will not apply to records and information that have already been provided.

EXPIRATION: Unless earlier revoked, *this authorization will expire one year after the date of this release*.

PATIENT RIGHTS: I have the right to inspect or copy the information to be disclosed as provided in 45 CFR § 164.524. I have the right to inspect and amend my medical records as provided in 45 CFR § 164.526. *I have the right to an accounting of the use and disclosure of my health information to any third party as provided in 45 CFR § 164.528.*

RE-DISCLOSURE: I understand that there is a potential for unauthorized re-disclosure of the information disclosed herein and that the re-disclosed information may not be protected by Federal confidentiality rules and regulations

PHOTOCOPIES OF THIS RELEASE ARE VALID AND MAY BE USED IN LIEU OF THE ORIGINAL.

By: _____ Date:_____

SSN: _____