# AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize ______________________________
   Name of hospital/physician

Health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. Patient Name: ______________________________ Date of Birth ____________

Address: ______________________________
Street City State Zip

3. Information to be disclosed to: Law Offices of Juliane Soprano
   P.O. Box 543
   Falmouth, MA 02541

4. Disclose the following information for treatment dates: ______________ to date and continuing

- [x] Complete Record
- [ ] Abstract
- [ ] Face Sheet
- [ ] Discharge Summary
- [ ] History & Physical
- [ ] Consult
- [ ] Outpatient Reports
- [ ] X-Ray
- [ ] Laboratory
- [ ] Pathology
- [ ] Physical Therapy
- [ ] Emergency Report
- [x] Other Specified any and all records to also include mental health, psychological and substance abuse.

5. The above information is disclosed for the following purposes:

- [ ] Medical Care
- [x] Legal
- [ ] Personal
- [ ] Other ____________

6. I understand I may revoke this authorization at any time by requesting such of the above referenced hospital/physician practice in writing unless action has already been taken in reliance upon it, or during a contestability period under the law.

7. This authorization expires (upon) Completion of legal issues
   (insert applicable date or event)

8. ______________________________
   Signature of Patient or Legal Representative

9. ______________________________
   Date

______________________________
Printed name of Patient or Patient's Representative

Self
10. Relationship to patient or authority to act for patient

11. This release is executed to assist with the preparation of my workers' compensation and/or social security case in the event of my death or incapacity during these proceedings, I hereby specifically state that it is my intention that this release shall service my death at least to conclusion of my workers' compensation and/or social security case.

______________________________ ______________________________
Signature of Patient or Legal Representative Date

**IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL NUMBERED ENTRIES ARE COMPLETED**