

**HIPAA AUTHORIZATION FOR USE/DISCLOSURE
OF PROTECTED INFORMATION**

TO RECORDS CUSTODIAN OF: _____

This authorizes and directs you to furnish to my attorneys and/or representatives of **THE LAW OFFICE OF CHRISTY R. JINDRA, LLC** any or all of the following information, records, documents, tapes, photographs, and other tangible items regarding me. **I further direct and instruct you not to release or disclose any information about my medical care or treatment to any insurance company or other law firm (except my own) without further express written and signed authorization from me. Any and all prior authorizations are hereby canceled and rescinded.** A photocopy of this authorization is as valid as the original.

This Authorization applies to the information checked below for the following date or dates of service:

From: _____ To: _____

I _____, DIRECT THAT THE FOLLOWING RECORDS BE RELEASED BY YOU

TO MY ATTORNEYS AND THEIR REPRESENTATIVES:

MEDICAL RECORDS INCLUDING: _____

- | | |
|---|--|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Gastro Intestinal (GI) Lab Reports |
| <input type="checkbox"/> Abstract of Record | <input type="checkbox"/> History and Physical Reports |
| <input type="checkbox"/> Financial Record | <input type="checkbox"/> Laboratory Test Results |
| <input type="checkbox"/> Itemized Statement | <input type="checkbox"/> Medication Records |
| (DO NOT REFLECT ANY PAYMENT) | <input type="checkbox"/> Neurodiagnostic Reports |
| <input type="checkbox"/> Ambulance Record | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Autopsy Report | <input type="checkbox"/> Pathology Slides/Blocks |
| <input type="checkbox"/> Cardiac Cath Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Consent Forms | <input type="checkbox"/> Physical/Occupational Therapy (PT/OT) Notes |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Radiology Films & Reports |
| <input type="checkbox"/> Dental Records | <input type="checkbox"/> Speech/Language Pathology Reports |
| <input type="checkbox"/> Diagnostic Images (x-rays, etc.) | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Diagnostic Photos | <input type="checkbox"/> HIV/AIDS Test Results Client's Initial: _____ |
| <input type="checkbox"/> Discharge Summary Reports | <input type="checkbox"/> Psychiatrist or Psychotherapist Mental Health treatment record Client's Initial: _____ |
| <input type="checkbox"/> Doctors Orders | <input type="checkbox"/> Other (Specify): _____ |
| <input type="checkbox"/> Echo Tapes | <input type="checkbox"/> Notes: _____ |
| <input type="checkbox"/> Electro Cardiogram (ECG/EKG) Reports | |
| <input type="checkbox"/> Emergency Room Record | |
| <input type="checkbox"/> Face Sheet | |

MEDICAL BENEFITS PAID ON MY BEHALF INCLUDING: _____

- | | |
|---|--|
| <input type="checkbox"/> Physicians | <input type="checkbox"/> Home nutrition services |
| <input type="checkbox"/> Hospitals | <input type="checkbox"/> Physical therapists |
| <input type="checkbox"/> Clinics | <input type="checkbox"/> Occupational therapists |
| <input type="checkbox"/> Home health care providers | <input type="checkbox"/> Speech therapists |
| <input type="checkbox"/> Nursing services | <input type="checkbox"/> Respiratory therapists |

EMPLOYMENT

- Employment records
- Personnel files
- Payroll records
- Wage and Salary Verification
- Applications for employment

POLICE & GOVERNMENT REPORTS

- Uniform Motor Vehicle Accident Report
- Accident scene photographs
- Supplemental reports
- Witness statements
- Investigation notes and reports

EDUCATION

- Student records
- Scholastic records
- Degrees, diplomas and certificates of completion and achievement

TAXES

- State returns
- Federal returns
- Quarterly filings

Purpose of Use or Disclosure:

- At the request of the individual**
- Other:**

I understand that individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws. The protected health information used or disclosed pursuant to this Authorization may be subject to re-disclosure to individuals or organizations that are not subject to HIPAA and may then no longer be protected by the federal privacy regulations.

I understand that **I have the right to revoke** this Authorization at anytime by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization.

Please send your notice of revocation to: **Christy R. Jindra**
Attorney at Law
135 Brandywine Blvd., Suite C
Fayetteville, GA 30214
(770) 716-1880

I understand that this Authorization is specific to the information checked above, for the dates of service indicated, and for the purpose written above.

I further understand that I am entitled to receive a copy of this signed Authorization, if requested.

Unless otherwise revoked, this Authorization expires in one year unless I specify another time:

Print the name of the Patient or Representative.

Patient's Date of Birth

Signature of Patient or Representative

Patient's Social Security Number

Authority of Representative, to act on behalf of the Patient

TODAY'S DATE

Any document outlining such authority should be attached.

(Relationship to Patient) _____

The patient is unable to sign because _____.

NOTE: If advance payment is required before the release of the requested records, please contact this office