AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (IN COMPLIANCE WITH ALL CORE ELEMENTS AND REQUIRED STATEMENTS PURSUANT TO 45 CFR §164.508)

Directed To: _____
Patient: _____Date of Birth:_____
Re: _____(*Style of case OR reason for request*)

I hereby Authorize and request, you furnish to Quality Records Retrieval, LLC, P.O. Box 3581, McKinney, Texas 75070, authorized agent for the Law Firm of _____, all of the following (unless otherwise noted):

- History/Physical
- Doctor's Notes/Office Notes
- Patient Intake Forms/Patient Information Forms
- Admissions/Initial Visit
- Consultations
- Discharge Summaries
- Copy of Entire Health Record OR from _____ to _____
- Copy of All Itemized Billing Statements/Billing Records from _____to_____
- Records from other health care providers which are maintained as part of your file
- Other _____

I understand that the information in my health record *may* include information relating to sexually transmitted disease, acquired immune deficiency syndrome (AIDS) or human immune deficiency virus (HIV), communicable or non-communicable diseases and genetic testing. It may also include information about behavioral or mental health services, information concerning alcohol or drug abuse and social and family matters.

A photostatic copy of this authorization is considered as effective as the original and will expire one year from date signed ***or*** at the conclusion of this litigation.

This release of the aforementioned records is only for evaluation and use in connection with civil litigation or other cause as referenced above.

I understand I have the right to revoke this authorization at any time, provided the revocation is in writing to Quality Records Retrieval and/or the firm listed above and the above listed Health Provider. Revocation of this Authorization will not affect information released prior to the notification of cancellation.

I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information, carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

I understand that my refusal to sign this form does not affect my health care treatment or the payment of my health care treatment, my eligibility or enrollment for benefits. Medical providers may not condition treatment or payment on execution of this authorization.

Signature of Patient or Patient Representative

_____

(If not the patient, please state your relationship to the patient)

_____

Date: _____