

**HIPAA COMPLIANT AUTHORIZATION FORM
FOR THE RELEASE OF EDUCATION RECORDS
PURSUANT TO 45 C.F.R. § 164.508**

Name or specific identification of the person(s), or class of person, authorized to make the requested disclosure:

Student Name: _____ A/K/A: _____
Date of Birth: _____ Social Security Number: _____
Address: _____

I authorize disclosure of all protected medical or other confidential information for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities HIPAA identified above disclose full and complete protected medical information spanning the time period of _____ to present including the following:

- All attendance records, teachers' notes and reports and disciplinary records.
- All guidance counseling records, psychology records, drug and/or alcohol counseling records.
- All medical/school nurse/infirmary records.
- All medical records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
- All radiology films, mammograms, myelograms, CR scans, photographs, bones scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- All pharmacy/prescription records include NDC numbers and drug information handouts/monographs.
- All billing records including all statements, itemized bills, and insurance records.

Information about alcohol/substance abuse and HIV/AIDS may be disclosed as follows: (check all that apply)

Yes, disclose HIV/AIDS information No, do NOT disclose HIV/Aids information
 Yes, disclose alcohol/substance abuse information No, do NOT disclose alcohol/substance abuse information

I authorize you to release the protected health information to **Litigation Management, Inc., 6000 Parkland Boulevard, Mayfield Heights, Ohio 44124.**

- I acknowledge the right to revoke this authorization by writing to the above counsel at the above address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under 45 C.F.R. § 164.508.
- I acknowledge the right to inspect the material to be released.
- I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.
- Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.
- This authorization expires two years from the date below.

Signature: _____ Date: _____

Relationship to person who is the subject of the records:

Self: _____ Other: _____

Describe Authority