HIPAA COMPLIANT AUTHORIZATION FORM
FOR THE RELEASE OF EDUCATION RECORDS
PURSUANT TO 45 CFR 164.508

Name or specific identification of the person(s), or class of persons, 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, psychological 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, bone 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)

__X__ **Yes, disclose HIV/AIDS information** ____ **No, do NOT disclose HIV/AIDS information**
__X__ **Yes, disclose alcohol/substance abuse information** ____ **No, do NOT disclose alcohol/substance abuse information**

I authorize you to release the protected health information to:

Defendant(s) Counsel

Gibbons, P.C.

One Gateway Center

Newark, NJ 07102-5310

and/or

Medical Research Consultants (MRC)

and/or

The Marker Group

I acknowledge the right to revoke this authorization by writing to Gibbons, P.C. at the above referenced 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 CFR 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 the person who is the subject of the records:

Self: ____X____ Other: _____
Describe authority