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

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

_____

_____

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

I authorize disclosure of all protected medical information for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information, including the following:

- **All medical records, including, but not limited to, physician's records; surgeon's records; inpatient, outpatient and emergency room treatment records; patient intake forms; consultations; hospital records; operating room records; progress and visit notes; diagnostic records; discharge summaries; nurse's notes; therapist's notes; consent for treatment; all clinical charts, reports, and/or documents; correspondence; test results; statements; questionnaires/histories/physicals; office and doctor's handwritten notes; records received by other physicians; and any other papers relating to any examination, diagnosis, treatment, periods of hospitalization, or stays of confinement, or documents containing information regarding protected health information in the medical records.**
- **All diagnostic testing, reports, records, films and/or videos, including, but not limited to, x-rays; CT scans; MRI (including MARS MRI); scans/photographs; pathology/tissue slides; bone scans; any and all laboratory testing reports, including all those related to blood ion levels; autopsy reports; and any other laboratory, histology, cytology, pathology, or radiology reports/specimens.**
- **All pharmacy/prescription records, which include NDC numbers, including, but not limited to, prescription records; medication records; orders for medications; and any drug information handouts/monographs.**
- **All billing records, including, but not limited to, all statements; statements of account; itemized bills; and insurance records.**

I authorize you to release the protected health information to:

**Gibbons P.C.**
**One Gateway Center**
**Newark, NJ 07102-5310**

**The Marker Group, Inc.**
**13105 Northwest Freeway, Suite 300**
**Houston, TX 77040**

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

The individual signing this authorization expressly authorizes the above-named entity to disclose HIV/AIDS records and information to Gibbons P.C. and/or The Marker Group, Inc., and authorizes re-disclosure of said records and information to consultants, experts, agents, and/or other counsel in this litigation.

The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.

I acknowledge the right to revoke this authorization by writing to Gibbons P.C. or the Marker Group, Inc. at the above referenced addresses. 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: _____ Other: _____

Describe authority: _____