Client Release of Medical Information (HIPAA)

Client's Name: _____ Date of Birth: _____

I hereby authorize _____ (Agency, Person or Institution)

_____ (Address)

_____

_____

to release the following information regarding my medical and/or psychological history, diagnosis and/or treatment to_____,_____my attorney and/or_____Paralegal assisting my attorney, at the above address and telephone number, with the knowledge that such release discloses the fact that medical and/or mental health services have been/are being provided. This information is required for the purpose of providing effective legal counsel in a criminal case.

This information shall be limited to releasing the following types of protected health information, regardless of date:

Entire record, including any or all of the following _____(initials)

Neurological Assessment ____ Psychological/Vocational Testing ____ Other Evaluation Assessments ____

Diagnosis ____ Lab Test Results, including X-rays, EEG, EKG, Radiological Tests ____

Prescriptions ____ HIV Testing ____ Assessments by Consulting Doctors ____

Social History ____ Treatment Programs ____ Other Materials (specifically): _____

_____

_____

I understand that this information may include reference to psychiatric care, sexual assault, alcohol/drug abuse, and the results of tests for all infectious diseases including AIDS/HIV.

I understand that I have the right to revoke this authorization at any time by notifying the Agency, Person or Institution named above in writing.

I understand that revocation will not apply to information that has already been released in response to this authorization.

I understand that the disclosure of this private health information is voluntary and that I can refuse to sign this authorization.

I understand that I may inspect or obtain a copy of the information to be used or disclosed.

I understand that this information will automatically expire one year from the date it is signed unless revoked sooner.

I understand that I am to receive a copy of this authorization.

I understand that I may refuse to sign this authorization without affecting my ability to obtain treatment.

I understand that Protected Health Information (PHI) used or disclosed as a result of my signing this authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

Signature of Client/Requestor _____ Date of Signature _____

Witness _____

Signature of Professional (Physician, licensed Psychologist or MSW) approving client initiated request for release of records: _____

****A PHOTOCOPY OF THIS RELEASE SHALL BE AS VALID AS THE ORIGINAL****