AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Pursuant to The Health Insurance Portability and Accountability Act of 1996 [45 C.F.R. 164.508])

Health Care Provider:_____
_____

Patient Name & Address:_____
_____

I consent to and authorize the above named Health Care Provider, and/or their duly designated billing or records agent to release to: **Thompson & Thompson, P.C., P.O. Box 901, Warsaw, NC 28398**

Medical information including physician or nurses note/summaries, diagnostic results, and itemized billing for the following periods:_____

The information will be used/disclosed for the following purposes (specify the reason for this request, e.g. Treatment, insurance, legal, etc.): _____**Legal**_____

Description of information that may be used/disclosed: This will authorize_____ **Thompson & Thompson, P.C.** or their duly authorized representatives, to examine, reproduce, or otherwise copy in any manner, and to discuss orally or obtain oral and written reports thereon as they may request, any of the following:

1. Any and all hospital records, x-rays and reports thereof, laboratory reports and records, all tests and reports thereof, statements of charges, and any and all records pertaining to my hospitalization (s);
2. Any and all medical records, including patient's record cards, file jackets, x-rays and reports thereof, laboratory reports and records, all tests and reports thereof, statements of charges, and any and all records pertaining to my medical care;
3. All notes, correspondence, or records of any other nature made by my physicians nurses or other persons concerning my, my condition, or my treatment;
4. All tissue blocks and/or tissue slides;
5. All pathology specimens or any nature;
6. All electron microscopy films and/or reports;
7. Any and all educational/or vocational records, reports, transcripts or other papers;
8. Any and all lien/ subrogation claims information for Medicare, Medicaid and third party insurers.

The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and/or HIV/AIDS, if applicable.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed by law. I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the Health Care Provider. I further understand that I may not revoke this authorization to the extent that action has been taken in reliance on this authorization. Unless revoked, this Authorization will not expire and will continue to be valid throughout the term of my representation by E.C. THOMPSON, III, and KENNEDY L. THOMPSON, Attorneys at Law of THOMPSON & THOMPSON, P.C. A copy of this signed Authorization is as effective and valid as the original.

This the_____ day of _____, 2021.

_____
Patient D.O.B

_____
Signature of Patient or Representative (if applicable)

Patient
Requestor/ Relationship

Witness:_____