

Authorization for Medical and/or Hospital Information

To: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Re: \_\_\_\_\_

I hereby authorize Robert E. Peterson, Attorney at Law to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Patient Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Information to be disclosed to: Robert E. Peterson, Attorney at Law, 520 Walnut Street, Suite 401, Des Moines, IA 50309 Office: 515-288-9350 Fax: 515-282-8470.

Disclose the following information for treatment dates: \_\_\_\_\_ to \_\_\_\_\_.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Complete Records  | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Outpatient Records    |
| <input type="checkbox"/> Face Sheet        | <input type="checkbox"/> Consult          | <input type="checkbox"/> Abstract              |
| <input type="checkbox"/> Emergency Reports | <input type="checkbox"/> X-Ray            | <input type="checkbox"/> Other Specified _____ |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Laboratory       | <input type="checkbox"/> History & Physical    |
| <input type="checkbox"/> Pathology         |   |  |

The above information is disclosed for the following purposes:

Medical Care                       Legal                                       Insurance  
 Personal                               Other \_\_\_\_\_

I understand I may revoke this authorization at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

I acknowledge and hereby consent to such, that the release information may contain alcohol and drug abuse, psychiatric, HIV or genetic information.

This authorization expires five (5) years from the date it was signed by the patient or the patient's authorized representative. Photocopies of this document will suffice for the original copy.

Said law firm has been retained by me to effect settlement of a claim against the insurance carriers or others for injuries sustained, and your full cooperation is respectfully requested. You are further requested to disclose no information to any insurance adjuster or any other person without written authority from me to do so.

Signed \_\_\_\_\_ (day) of \_\_\_\_\_ (month), \_\_\_\_\_ (year).

\_\_\_\_\_  
Signature of Patient or Personal Representative  
\_\_\_\_\_  
Printed Name

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Public

My Commission Expires:

**Pursuant to HIPAA Private Rule §164.508**