

**LUKS, SANTANIELLO,
PETRILLO & JONES**

**AUTHORIZATION FOR RELEASE OF GENERAL PERSONAL HEALTH
INFORMATION PURSUANT TO HIPAA**

| | |
|------------------|-------------------|
| Name: | Provider Name: |
| Street Address: | Dates of Service: |
| City/State/Zip: | Dates of Service: |
| DOB: | SSN: |
| MEDICARE/HICN #: | |

1) I, _____ hereby authorize the above health care provider, its agents, employees and associates, to release the personal health information that is described below, to Luks, Santaniello, Petrillo & Jones, its agents and employees.

2) The personal health information released herein is specifically as follows:

The entire medical records including, but not limited to, any and all reports, any and all notes (doctors', nurses' and physical therapists'), consultation reports and records, tests, test results, x-ray reports, radiology reports, patient forms, correspondence, notes and memorandum related to said person's care and treatment rendered at any time or date by or through your office, company or facility, billing, insurance and invoices.

3) This personal health information is to be used in a Workers' Compensation/Liability claim, including, but not limited to, submission to experts, advisors, litigants, insurance carriers, courts, or even court files and the Center for Medicare & Medicaid Services (CMS).

4) This release may be revoked by a signed and properly dated written revocation, delivered to the health care provider's record custodian or business associate, provided that this release cannot be revoked as to personal health information which had been previously release in reliance on this document.

- 5) I understand that a refusal to sign this form will not result in denial of health care by the hospital or any other health care provider and that this release has not been coerced by a health entity or any of its business associates.

- 6) I understand that once the personal health information is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, insurance companies and even may become public record if filed with a court of law.

- 7) This authorization and/or copies of this authorization expire within four (4) years of the date herewith listed on this HIPAA form.

Dated this ___ day of _____, _____.
 DD MM YY

_____ Date: _____
Signature of Claimant or Legal Representative

_____ Date: _____
Relationship to Claimant if Legal Representative

A copy of the document giving the Legal Representative the authority to sign this Authorization must be attached, with except of Legal Representative acting in capacity as a parent to a Claimant.

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