AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

DATE OF ACCIDENT: _____ S. S. NO.: _____

THE FOLLOWING HEALTH PROVIDER IS AUTHORIZED TO PROVIDE MEDICAL RECORDS AND DISCLOSE PATIENT IDENTIFIABLE HEALTH INFORMATION:

NAME: _____ PHONE: _____

ADDRESS: _____ FAX: _____

The above named health provider is authorized to discuss my medical treatment and health information with FISHER LAW GROUP, PLLC – CHATTANOOGA herein after referred to as DONALD W. FISHER & ASSOCIATES and named health provider is NOT authorized to discuss my medical treatment or health information with _____ Insurance Company.

The scope of the Protected Health Information (PHI) to provided or disclosed is as follows: All medical records for all dates of service for all medical conditions and treatment from other health care providers and facilities, including but not limited to psychiatric care, substance abuse, or HIV status. All billing records regarding the referenced incident. All medical release authorizations, notes, memoranda, correspondence, claim forms, reports and insurance documents regarding the referenced client.

The health information is authorized to be provided to:

FISHER LAW GROUP, PLLC – CHATTANOOGA
DONALD W. FISHER & ASSOCIATES
6432 Hixson Pike; Chattanooga, Tennessee 37343
phone number: 423-305-7999 – fax number 423-475-6259

My attorneys are authorized to act on my behalf regarding all insurance and legal matters. The patient identifiable health information received pursuant to this release authorization is to be used for the following purpose:

No-fault (PIP/Med-Pay) insurance claims, liability claims, underinsured motorist claims, workers' compensation claims and all other insurance or legal matters related to my injuries or health condition.

RIGHT OF REVOCATION: I have the right to revoke this release authorization at any time. The revocation must be in writing and be delivered to The Law Firm of Donald W. Fisher & Associates. The revocation will only apply to records and information that have already been provided. **EXPIRATION:** Unless earlier revoked, this authorization will expire upon the termination of the representation by Law Firm of Donald W. Fisher & Associates. **PATIENT RIGHTS:** I have the right to inspect and amend any medical records, and to an accounting of the use and disclosure of my health information to any third-party as provided in CFR 164.528. RE-**DISCLOSURE:** I understand that there is a potential for authorization re-disclosure of the information and that re-disclosure information may not be protected by federal confidentially rules.

PHOTOCOPIES OF THIS RELEASE ARE VALID AND MAY BE USED IN LIEU OF THE ORIGINAL.

_____ _____

DATE **PATIENT**

If you are signing as a Power of Attorney, Legal Guardian, Executor, or Administrator complete the following and attach a copy of the supporting legal documents.

_____ _____

DATE **PERSONAL REPRESENTATIVE/ RELATIONSHIP**