AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION TO THE LAW OFFICE OF PHILLIP COREY LEVIN. P.A.

Phillip Corey Levin, Esq
1111 Park Ave., Suite L-150 Sutton Place
Baltimore, MD 21201
410-523-0991 PHONE, 410-225-7532 FAX
gotpcl@gmail.com

TO: _____ DATE: _____
Medical Provider Treatment Date

This will authorize you to release to the office of the above attorney or agents thereof, all medical records of whatever nature, mental health records, billing statements, radiological films, pathology material, photographs, videos and other information concerning:

_____ _____ _____
Patient Name SS Number Date of Birth

This authorization; specifically, but not limited to, includes release of the following information:

Admission History & Physical	_____	Mental Health Records	_____
Operative Reports	_____	Consultation Reports	_____
Pathology Reports	_____	X-ray Reports	_____
Emergency Room Records	_____	Outpatient Records	_____
Drug/Alcohol Treatment Record	_____	Other (see below)	_____
		Medical Billings	_____

Others
(specify) _____

The purpose of the release of this information is to obtain any and all information regarding medical treatment rendered as a result of an accident claim on _____ and is at the request of the individual whose signature is listed below.

This will also authorize you to speak to and disclose orally any information relating to diagnosis, care, treatment, prognosis, opinions and billings with regard to the above or the above attorney's office to any agents thereof.

I understand that I have the right to revoke this authorization; however the revocation must be in writing. Revoking this authorization will not have any effect on actions that the health care provider took in reliance on the authorization before the health care provider received. notice of the revocation. The information to be disclosed may be protected by law. Information disclosed under this authorization may be redisclosed by the recipient and no longer protected by federal privacy regulations. I understand that my ability to receive health care treatment from the health care provider will not be affected in do not sign this form. However, without my signature, this request to release the information described above will not be honored. The protected health care information provided under this authorization may include diagnoses and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable disease (including HIV AIDS) and/or genetic marker information. These records will be included in the information we will make available to the individual organization I have identified above.

This authorization expires on _____ 20 _____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure· of information about me: _____

_____

I have read the above and authorize the disclosure of the protected health information as stated:

_____ _____ _____
Date Signature of Patient/Parent/Patient Representative Relationship to Patient

A PHOTOCOPY OF THE AUTHORIZATION MAY BE USED IN LIEU OF THE ORIGINAL