ATTORNEYS JO ANN HOFFMAN & ASSOCIATES, P.A.

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION (H.I.P.A.A.)

I hereby authorize the named health care provider to release the information or records specified to ATTORNEYS JO ANN HOFFMAN & ASSOCIATES, P.A. at the address listed above.

PROVIDER: (name and address)	
_____	**PATIENT**: _____
_____	**SSN:** _____
_____	**DOB:** _____

RECORDS AUTHORIZED TO BE RELEASED:

☒ All PHI in medical record	☒ Special tests	☐ Transfer forms	☐ Complete hospital chart
☒ Admission form	☒ Itemized bill	☐ Nursing information	☐ Outpatient records
☒ Dictation/reports	☒ ER Information	☐ UB -92	☐ Lab reports
☒ Physician orders	☒ Office notes	☐ Medication sheets	☐ Radiological images
☒ Intake/outtake	☒ Operative information	☐ Clinical tests	☐ Therapy notes
☒ Consultation notes or reports			

☐ Other (specify): _____

_____

THIS INFORMATION WILL BE USED FOR THE PURPOSE OF:

☒ Providing advocacy services
☒ Legal representation relating to an accidental injury which occurred on _____.
☐ Other activities at the request of the individual

THIS AUTHORIZATION WILL EXPIRE ON _____.

I understand that I can revoke this authorization at any time by writing to the health care provider or to Attorneys Jo Ann Hoffman & Associates, P.A., but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization.
- I am entitled to receive a copy of this authorization.
- The covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign the authorization.
- Federal privacy regulations will no longer apply to the information disclosed, and that my attorneys may re-disclose the information.
- A copy of this authorization may be utilized with the same effectiveness as an original.

✓ _____
Patient or Representative Date

_____
Name of Patient or Representative (print)

_____
Relationship to Patient