AUTHORIZATION TO RELEASE MEDICAL RECORDS AND HIPAA RELEASE

TO: **Any and all hospitals, emergency rooms, treatment facilities, psychologists, psychiatrists, physicians, counselors, nurses, insurance providers or other persons, entities or institutions, having documents or records relevant to myself.**

I, _____, do hereby AUTHORIZE you to discuss with, testify, and provide to KAYE M. ALDERMAN, Attorney, or any representative of The Law Office of Kaye M. Alderman, 124 East Lufkin Avenue, Lufkin, Texas, a complete copy of all records and/or documents related to my treatment, including results of and records related to any HIV testing and/or chemical dependency testing and/or records in your possession, custody or control reflecting the date treatment was sought and/or rendered and the nature of the treatment sought and/or rendered, records of any and all medications prescribed or administered, any and all emergency room records, including admittance forms and/or discharge forms, any and all hospital records, including all physician notes, nurse or assistant notes, any and all invoices or billing statements, reports, and correspondence, reports of diagnostic and/or psychological or psychiatric tests administered, any and all laboratory reports, photographs (excluding x-ray films), and every other such record to which you may have access pertaining to any medical psychological and/or psychiatric services rendered to me.

You, the institution and/or person listed hereinabove, are hereby relieved of any liability and/or responsibility to any alleged cause of action or complaint arising by your obedience to this authorization. I, _____ understand that my rights pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which makes all such records and documents referenced in this release regarding my medical care and treatment confidential and not subject to disclosure; however, I hereby WAIVE such privacy rights to the extent indicated in this Authorization. This Authorization shall be effective beginning on the date of execution and shall continue in full force and effect for twelve months following the date of execution, at which time this Authorization shall terminate.

I, the undersigned, have read the above and authorize the staff of any and all hospitals, emergency rooms, treatment facilities, psychologists, psychiatrists, physicians, counselors, nurses, insurance providers or other persons, entities or institutions to disclose such information as herein contained. I understand that I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all1iabilitity and damages resulting from the lawful release of my Protected Health Information.

A copy of this Authorization shall have the same force and effect as the original.

BY: _____

STATE OF TEXAS §

COUNTY OF _____ §

This instrument was acknowledged before me on _____ 2016 by _____.

_____
NOTARY PUBLIC STATE OF TEXAS