

AUTHORIZATION TO RELEASE RECORDS, INFORMATION & DATA

Patient Name: _____

Social Security Number: _____

Health Care Provider: _____

I (the above identified Patient or that Patient's personal representative) have retained the law firm identified in this Release to represent me in certain matters. So they may better represent me, it is my intent and desire that my attorneys have full and complete access to any and all records, information and data in your possession, under your control or that you have access to, including but not limited to hospital records, nursing home records, doctor records, dental records, psychiatric records, drug treatment records, HIV treatment and evaluation records, therapy records, diagnostic studies, lab studies, as well as any and all other records, information or data that would describe care, treatment or services rendered to the above described Patient by any health care provider or mental health care provider. I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), HIPAA regulations, as well as other Federal and State laws and regulations, create a right of privacy that is associated with the records, information and data covered by this release. So that my attorney's may better advise me, and consistent with 45 CFR § 164.508, I expressly authorize you to release the Patient's records, information and data to my attorneys and, as necessary, make a limited waiver of my privacy right for the purpose of giving my attorneys access as follows:

- (1) **The information to be disclosed is as follows:** I expressly authorize my attorneys to request any and all records, information or other data (regardless of how those items are identified) related to any and all care, treatment or services provided for the above identified Patient's physical health, mental health, or psycho-social health. Throughout the remainder of this Release, I collectively refer to all of the Patient's records, information and data as the "Records." This Release is intended to be general, full and all encompassing so that my attorneys can access, without limitation, any and all Records that might help them represent me. This Release applies to any and all Records that are in your possession, under your control or that you have access to. My attorneys are further authorized to limit their request to portions of the Patient's Records and may do so by letter to you. My attorneys are further authorized to meet with and consult with any health care or mental health care provider regarding my condition or regarding any care, treatment or services that the above identified Patient received. I expressly invoke the AMA Principals of Medical Ethics, as well as Canon E-9.07, as well as similar ethics principals that may apply to other health care disciplines, and request that you co-operate with my attorneys.

- (2) **The persons who may request disclosure are as follows:** David N. Rainwater, together with those persons working for him at the law firm of Rainwater & Harpe, LLP are authorized to request my records. My attorney's address is below:

Rainwater & Harpe, LLP
109 E. 14th Avenue
P. O. Box 1096
Cordele, GA 31010

- (3) **The persons to whom information may be disclosed:** The information requested shall be disclosed to my attorneys identified in the preceding paragraph, or to any nurse consultant or physician who is assisting them. The information requested may be sent to either of my attorney's office addresses listed above.
- (4) **Term of this Release:** It is my intent that this authorization shall remain effective throughout the time during which my attorneys are representing me. To the extent a term is required; this Release shall be effective for a term of not less than five (5) years from the date of execution.
- (5) **Right to Revoke this Release:** I understand that I always retain the right to revoke this Release. However, this Release shall not be revoked while my attorneys are representing me. All previous releases are hereby revoked.
- (6) **Disclosed Records, Information and Data may not be Protected:** I understand that the information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by 45 CFR § 164.508, or other privacy laws and regulations.

DATE: _____

PATIENT (or Personal Representative)

LEGAL AUTHORITY: IF THIS RELEASE RELATES TO NURSING HOME CARE, THEN THE REQUEST IS AUTHORIZED PURSUANT TO 42 CFR § 483.10(b)(2), AS WELL AS STATE RESIDENT RIGHTS LAWS. THE RESIDENT OR HIS OR HER LEGAL REPRESENTATIVE SHALL HAVE THE RIGHT UPON ORAL OR WRITTEN REPORT TO ACCESS ALL RECORDS WITHIN 24 HOURS, INSPECT SUCH RECORDS AND OBTAIN A COPY OF SAID RECORDS WITHIN 48 HOURS ADVANCE NOTICE TO THE FACILITY.