McCORKLE
LITIGATION SERVICES

200 North LaSalle Street
Suite 770
Chicago, Illinois 60601
(800)-MCCORKL

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Pursuant to HIPAA Rule 45 CFR § 164.508

PATIENT INFORMATION

First Name ______ Middle Name ______ Last Name ______

Address ______ City ______ State ______ Zip Code ______

Phone Number ______ Date of Birth ______ Last 4 of Social Security Number ______

I hereby grant permission for ________________________________ to release a copy of my bills and/or medical records.

MEDICAL RECORDS TO BE RELEASED

Date(s) of Service____________________ to ____________________ **Requested Delivery Date: WITHIN 30 DAYS**

INFORMATION TO BE RELEASED:

- ☐ **Emergency Room Visit** (ER Notes, Progress Notes, Consultations, Procedure Notes, Test Results)
- ☐ **Hospital Stay** (History and Physical, Progress Notes, Consultations, Operative Reports, Discharge Summary, Test Results)
- ☐ **Outpatient Surgery/Procedure** (History and Physical, Progress Notes, Consultations, Procedure Notes, Test Results)
- ☐ **Clinic, Office Visits or Immediate Care** (Office Notes, Progress Notes, Procedure Notes, Test Results)
- ☐ **Physical/Occupational Therapy Reports**
  Specify Clinic, Office or Physician____
- ☐ **Test Results/Reports Only** (Labs, Pathology, Radiology)
- ☐ **Substance Abuse Treatment Labs**
- ☐ **Substance Abuse Progress Notes**
- ☐ **Cardiac Reports**
- ☐ **History and Physical Examination**
- ☐ **Discharge Summary and Instructions**
- ☐ **Operative/Procedure Report**
- ☐ **Medication Records**
- ☐ **Psychological Evaluations**
- ☐ **Run Reports**
- ☐ **EKG/Stress Tests Records and Results**
- ☐ **Progress Notes**
- ☐ **Documentation for Excused Time off From Work/School**
- ☐ **Billing statement (HCFA / UB-92)**
- ☐ **All Reports Listed**
- ☐ **Other**:____

Method of Delivery: ☐ Fax – (312)263-7494 ☐ Email – records@mcdeps.com
☐ US Mail – 200 North LaSalle Street, Suite 770, Chicago, Illinois 60601
Format: ☐ CD ☐ Paper

MEDICAL IMAGES TO BE RELEASED

Date(s) of Service____________________ to ____________________ **Requested Delivery Date: WITHIN 30 DAYS**

- ☐ Radiology Images (Specify CT, MRI, X-Ray, Ultrasound, Nuclear Med)____
- ☐ Mammography Images
- ☐ Cardiology Images
- ☐ Include Reports with the Images

Other (Specify)____

PURPOSE OF INFORMATION RELEASE

To be used for the purpose of attorney review

NOTICE TO PATIENT

I understand that the information released upon authority of this authorization may contain information concerning treatment for a sexually transmitted disease, alcohol, drug abuse, genetic testing and/or genetic counseling records, mental health and developmental disability records, HIV test results, an AIDS diagnosis, or AIDS-related condition. I further understand authorization does not include permission to release outpatient psychotherapy notes.

This authorization is valid for a period of one (1) year from the date of completion of this authorization, and may be revoked by me in writing at any time, except to the extent that action has been taken in reliance. The revocation must be provided to the above-named facility.

I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law.

I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164].

The federal confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug or alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 1. A general authorization for the release of medical or other information DOES NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52FR21809, June 9, 1987; 52 FR4 1997, November 2, 1987)

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

SEND INFORMATION TO

The copies of the bills/medical records for services are to be released to McCorkle Litigation Services, 200 North LaSalle Street, Suite 770, Chicago, Illinois 60601, Fax – (312)263-7494 or email: records@mcdeps.com

By signing below, I agree to the statements in this Authorization form.

- **Patients 12–17 years of age** must sign for mental health and developmental disability, substance abuse/alcohol treatment, AIDS or HIV testing or test results, sexually transmitted infections, pregnancy, sexual assault, or birth control information.
- **Witness/Signature** is required for mental health and developmental disability information, and genetic counseling to recipient other than patient/self.

____ ____________________

Signature of Patient or Personal Representative **Date**

____ ____________________

Witness Signature **Date**