AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I hereby authorize _____ to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Patient Name: _____

Date of Birth: _____/_____/_____

Address: _____

Information to be Disclosed to: James Sweeney Esq. & Associates, PLLC
1 Properietors Drive, Second Floor
Marshfield, MA 02050

Disclose the following information from all treatment dates from and after_____.

Complete records and bills, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

The above information is disclosed for the following purposes: **LEGAL & INSURANCE**

I understand that I may revoke this authorization at any time by requesting such of the above referenced hospital/physician practice in writing unless action has already been taken in reliance upon it, or during a contestability period under applicable law. I further understand that a copy of this authorization shall have the same force and effect as an original.

This authorization expires upon termination of attorney client relationship between patient the above mentioned law firm and/or any attorney associated therewith.

I understand that HIPAA Privacy regulations prohibit conditioning of treatment, payment, enrollment, or eligibility for benefits on getting this authorization.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Name of Patient (Printed) Relationship to Patient/
Authority to Act