AUTHORIZATION FOR RELEASE OF INFORMATION *Document 12*

I HEREBY AUTHORIZE RELEASE OF MY PROTECTED HEALTH CARE OR RELATED INFORMATION AS DESCRIBED BELOW

Persons/Organizations Providing the Information:	Persons/Organizations Receiving the Information:
	_____, ESQ. **And/or persons acting on his behalf** **ADDRESS**

The records and information are being requested at the direction of the individual and are required in order to evaluate the nature and extent of injuries and/or illness claimed by the individual relating to an accident that occurred on or about DATE OF ACCIDENT, and to evaluate and prosecute said individual's claim related to said accident.

Specific description of information to be disclosed: Entire medical chart including, but not limited to, hospital records and/or reports, doctors' office records and/or reports, x-ray films and/or reports, MRI films and/or reports, any other radiological films and/or reports, medical billing records, Social Security records, Workers' Compensation records, police reports and/or photographs, other investigative reports, insurance records, including no-fault records, school records and/or transcripts, employment records and/or lost wage records, and income tax records.

I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.

Initials ☐

I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information. The revocation will only be effective from the date the written revocation is provided and will not apply retroactively.

Initials ☐

I understand that this authorization will expire One (1) Year from the date of the original signature indicated below. A photocopy of this Authorization has the same effect as the original.

Initials ☐

PRINTED NAME OF PATIENT:

SOCIAL SECURITY NO.: DATE OF BIRTH:

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE:

_____ DATE:

PATIENT'S PRINTED NAME

REPRESENTATIVE'S RELATIONSHIP TO PATIENT:

STATE OF NEW YORK)
COUNTY OF ERIE) SS:

On the _____ day of _____, 20_____, before me personally appeared NAME, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument, and who acknowledged to me that s/he executed the same in her/his capacity, and that by her/his signature on the instrument, the individual or the person upon behalf of which the individual acted, executed the instrument.

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