AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION
(Submitted in compliance with HIPAA requirements)

Patient Name: **Patient Date of Birth:** **SSN:**

TO: ____ **Phone:**___________________________

I hereby authorize you and your employees, agents, or representatives to disclose to my legal representative, **Kelly & Bramwell, P.C., 11576 S State, Bldg 1002, Draper, Utah, 84020, *all*** medical and related financial records or documents they may request, in any form, such as copies, abstracts, or excerpts, including but not limited to the following checked items, and any other information that you have in your custody or under your control which is requested by my attorneys for my own personal use.

___ History & Physical Reports	___ Nursing Notes	___ Billing Statements, Ledgers & Claims
___ Admission & Discharge Summaries	___ Doctors Orders	___ All Diagnoses including HIV & AIDS
___ Consultations	___ Social Service Notes	___ Progress Notes
___ Mental Health Notes & Directives	___ Allergy Notes	___ Payment Records
___ Medication Notes, Charts & Orders	___ Immunization Records	___ Visual/Opthalmological Reports/Tests
___ Nutrition Notes & Orders	___ Operation Reports, Notes & Orders	___ Anesthesiology Reports & Notes
___ Post Op & Pre-OP Notes & Orders	___ Physician Letters & Memoranda	___ Insurance Reports & Letters
___ Office & Treatment Notes/Clinic Notes	___ ICU Notes, Orders & Reports	___EEG, EKG & EMG Reports
___ Biopsy Reports/Tissue Sample Slides	___ Referrals	___ Spinal Procedure Reports/Notes
___ Consents for Transfer/Surgery/Trmnt.	___ NCV Reports	___ Prescriptions
___ Dental Notes & Evaluations	___ Transfer Records	___ Nerve Conduction Reports
___Home Health Care Notes/Orders/Report	___ Behavior Tests & Reports	___ Misc. Therapy Notes, Reports, Orders
___ Phone Call Records	___ Lab Tests, Orders & Reports	___ Academic & IQ Tests & Reports
___ Audiology Reports, Tests, Notes	___ Drug and Alcohol Reports, Notes	___ Radiology Reports
___ Occupational Therapy Notes & Reports	___ Ambulance & EMT Records/Notes	___ Admission Forms
___ Imaging Reports	___ Emergency Records & Notes	___ Nuclear Imaging, Photos, Ultrasounds
___ Xrays, MRIs, CTs,	___ Other:	___ All of the Foregoing List

I understand that the information requested may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and/or treatment for alcohol or drug abuse. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by confidentiality rules. I am signing this form voluntarily and understand that treatment and payment may not be conditioned on obtaining this authorization. This authorization shall remain in force and effect until it expires one (1) year from the date set forth below. A copy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to revoke or rescind this Authorization at any time by sending or presenting my written revocation to the health care provider named above. I understand that revocation of this Authorization will not apply to the extend that the health care provider has taken action in reliance thereon.

DATED: ________________________ ____

Patient/Patient's Representative

STATE OF ______ ____________________)
:ss
COUNTY OF _________________________)

SUBSCRIBED AND SWORN TO before me this ________ day of ________________________ , 20_______ .

____

Notary Public