HAIT & KUHN
NORTH METRO LITIGATORS

Family Law, Personal Injury, Bankruptcy and Divorce

www.northmetrolitigators.com

HIPAA AUTHORIZATION FORM

I, ________________________, hereby authorize use or disclosure of protected health information as described below:

1. The following person or class of persons or facility authorized to make the requested use or disclosure:

2. The following person or class of persons may receive disclosure of protected health information about me:

   Name: North Metro Litigators
   Hait & Kuhn
   185 Stockwood Dr., Suite 100
   Woodstock, GA 30188

3. The specific information that should be disclosed is: **All records and bills**, including, but not limited to, all health care and hospital records concerning medical treatment, dental treatment, psychiatric treatment, psychological treatment, HIV/AIDS, drug abuse, sexual abuse, chiropractic treatment, physical therapy, including, but not limited to, intake forms and questionnaires; medical history and physical exam notes and reports; admission and discharge records; patient record cards; telephone and e-mail messages; medical reports; progress notes and reports; nursing notes and reports; operative notes and reports; consultation notes and reports; physician orders; medication records; diagnostic tests; x-rays, x-ray readings, and x-ray reports; laboratory records, reports, and results; pathology reports; EKG, EEG, CT scan, MRI, and all other special tests and test results; emergency room reports; bills for treatment received by me; and all other records pertaining to examination, diagnostics and treatment, disability applications, disability determinations of insurance or government agencies, and disability and impairment ratings.

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying the Provider in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

6. I authorize and understand that a photocopy or facsimile of this original document will be accepted in lieu of the original document, as necessary.

7. I understand that the purpose of the disclosure is for use in a litigation in which I am a party.

8. This authorization expires six (6) months after the date of signature. This _____ day of ______________, 201_____.

Social Security Number: __________-______-__________

Date of Birth: ______________________________

Date(s) of Services: ____

______________________ Client Signature

______________________ Print Name

______________________ WITNESS

Sworn to and subscribed before me this ____ day of __________, 201_____.

________________________ Notary Public   My commission expires:___________ (NOTARIAL SEAL)

(p) 770-517-0045
(f) 770-517-0350

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Woodstock, GA 30188

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