AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____. (print name Client/Patient) Date of Birth____/____/_____.

hereby authorize the following individual or organization/entity _____.

(address) _____.

to use and/or disclose protected health information maintained by the Practice

regarding _____. (print name client/patient) as described below:

I authorize the following organization to receive the information:

Name: **KEVIN F. KURGIS CO., LPA**
Street Address: **100 SOUTH FOURTH STREET, SUITE 300**
City, State, Zip Code: **COLUMBUS, OHIO 43215**

The following identifiable health information may be used and/or disclosed:

_____. Billing Records (Itemized Statement) For Dates of Service _____.

_____. Medical Records (Entire Record) For Dates of Service _____.

_____. Laboratory Results For Dates of Service _____.

_____. All Treatment/Examination Dates (Notes/Records) For Dates of Service _____.

_____. Other (please specify) _____. For Dates of Service _____.

Reason of purpose for the use and/or disclosure of the information: **Personal Injury Claim**

I understand that the information in my health record 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 treatment for alcohol and drug abuse.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:
.
If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I shall receive a copy of this authorization, upon request. I understand any disclosure of information carries with it the potential of an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____. _____.
Signature of Client/Patient or Legal Representative Date

_____.
If signed by Legal Representative, Relationship to Client/Patient