HIPAA COMPLIANT, UNQUALIFIED AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
TO Jeffrey Allen Howard, ATTORNEY AT LAW, PLLC
1829 E. Franklin St.
Bldg 600
Chapel Hill, NC 27514

SECTION A: [Must be completed for all authorizations]

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health care provider, the released information may no longer be protected by federal privacy regulations, and there is a potential for unauthorized re-disclosure.

Patient name: _____ D.O.B. _____

ID [or Chart or SS] Number: _____

Persons/organizations providing the information (health care provider): _____

Persons/organizations receiving the information: Jeffrey Allen Howard (Attorney for the undersigned requestor)

Specific description of information: ENTIRE CHART – EVERYTHING YOU HAVE, INCLUDING BILLING STATEMENTS, FOR EVERY VISIT FOR WHATEVER REASON FROM THE DATE OF THE PATIENT'S BIRTH TO THE PRESENT, INCLUDING BUT NOT LIMITED TO INFORMATION RELATING TO COMMUNICABLE AND/OR SEXUALLY TRANSMITTED DISEASE,S, 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.

SECTION B: [Must be completed only if a health plan or a health care provider has requested the authorization]

1. The health plan or health care provider must complete the following:

   a. What is the purpose of the use or disclosure? INSURANCE CLAIM

   b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

   Yes _____ No _____

2. The patient or the patient's representative must read and initial the following statements:

x _____ a. I understand that my health care and the payment for my health care will not be affected if I do sign this form.

x _____ b. I understand that I may see and copy the information described on this form, with the exception of NONE, if I ask for it, and that I get a copy of this form after I sign it.

SECTION C: [Must be completed for all authorizations]

The patient or the patient's representative must read and initial the following statements:

x _____ a. I understand that this authorization will expire on FOUR (4) YEARS FROM THE DATE BELOW.

x _____ b. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any effect on any actions they took before they received the revocation.

Signature of patient or patient's representative:

x _____

Form must be completed before signing.

Dated: x _____

Printed name of patient's representative:

_____ Relationship to the patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION