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MEDICAL AUTHORIZATION AND RELEASE FORM

To: _____
Address: _____
_____
_____

I, the undersigned, do hereby authorize, the above mentioned provider to make full disclosure and to deliver all reports, data, facts and information **from:** _____ **to** _____to the law office of **Byron A. Lassiter & Associates, P.C., 2021 Dauphin Street, Mobile, Alabama 36606**, in connection with or related to this claim for authorization and request, and any information available shall be disclosed fully to my attorney. The purpose of this disclosure is the representation of the undersigned in a claim for benefits under Title II and/or XVI of the Social Security Act.

I, the undersigned, understand the following:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my healthcare and the payment of my healthcare, will not be affected.
3. I may revoke this authorization at any time, in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if I ask for it.
5. This information has the potential of redisclosure by the recipient and may no longer be protected considering this is a legal claim and all evidence must be submitted to the ruling parties.
6. The information released in my records may include information on the treatment of drugs and/or alcohol, HIV, AIDS or other sexually transmitted diseases, psychiatric treatment for depression or other mental illness. _____
Initials
7. This release expires one year from the signed date.

Your full cooperation is respectfully requested.

Date _____ X_____
SSN: _____
DOB: _____

Date _____ **Witness** _____
In accordance with section §164.508 of the HIPAA privacy regulations