AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(HIPAA and HITECH Compliant)

Patient Name:_____ Date of Birth:_____

Social Security No.:_____

**The following health provider is authorized to provide medical records and disclose patient identifiable health information:**

Name:_____ T:_____

Address:_____ F:_____

The above named health provider is authorized to discuss my medical treatment and health information with my attorneys, Goldfinch Winslow, LLC.

**Scope of health information (HIPAA and HITECH compliant) to be provided or disclosed is as follows:** All medical records for all dates of service for all medical conditions and treatment from the above named health care provider, as well as all medical records for all dates of service for all medical conditions and treatment from other health care providers and facilities. This is including all diagnostic testing including but not limited to radiological films. All billing records regarding the referenced incident. All medical release authorizations, notes, memoranda, correspondence, claim forms, reports and insurance documents regarding the referenced incident. A medical provider should maintain an audit trail/event log that specifies Logon Events, Account Logons, Object Access, Process Tracking, Policy Change, Account Management, Directory Service Access, System Events, any addition, changes or deletions to an electronic medical record and the designation of the person making any changes to a medical record. We are hereby requesting any audit trail/event log pursuant to the HITECH Act and HIPAA for the medical record requested pursuant to this authorization.

The health information is authorized to be provided to:

Goldfinch Winslow, LLC
Post Office Box 829
Murrells Inlet, SC 29576
**t.** 843.357.9301 / **f.** 843.357.9303

This authorization allows any employee of the law firm of Goldfinch Winslow, LLC, to speak with any employee of the above-named medical provider. My attorneys and their employees are authorized to act on my behalf regarding all insurance and legal matters. The patient identifiable health information received pursuant to this release authorization is used for the following purpose: No-fault (PIP) insurance claims, liability claims, underinsured motorist claims, workers' compensation claims and all other insurance or legal matters related to my injuries or health condition.

**RIGHT OF REVOCATION**: I have the right to revoke this release authorization at any time. The revocation must be in writing and be delivered to Goldfinch Winslow, LLC. The revocation will not apply to records and information that have already been provided.

**EXPIRATION**: Unless earlier revoked, this authorization will expire upon the termination of the representation by Goldfinch Winslow, LLC.

**PATIENT RIGHTS**: I have the right to inspect or copy the information to be disclosed, to inspect and amend my medical records, and to an accounting of the use and disclosure of my health information to any third party, as provided in 45 C.F.R. § 164.524. My treatment, payment, enrollment or other eligibility for benefits may not be affected by, or conditioned upon, my signing or my failing to sign, this authorization. I further understand the information in my medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services and treatment for alcohol and drug abuse.

**RE-DISCLOSURE**: I understand that there is a potential for unauthorized re-disclosure of the information and that the re-disclosed information may not be protected by federal confidentiality rules.

**Photocopies of this release are valid and may be used in lieu of the original.**

Date:_____ Signature:_____