LAW OFFICES OF DAVID I. FUCHS, P.A.

Attorney & Counselor At Law
www.davidfuchslaw.com

Admitted Florida, New York and District of Columbia

- *Personal Injury*
- *Wrongful Death*

8 Southeast 8th Street
Fort Lauderdale, Florida 33316

Tel: 954-568-3636
Fax: 954-462-4012

RECORDS RELEASE AUTHORIZATION

PATIENT NAME: _____

BIRTH DATE: _____

SOC. SEC. NO. _____

TO: _____

_____

I HEREBY AUTHORIZE _____ *TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING PERSONS OR CLASS OF PERSONS:*

LAW OFFICES OF DAVID I. FUCHS
8 SOUTHEAST 8TH STREET
FORT LAUDERDALE, FL 33316
954-568-3636
954-462-4012 fax

THE INFORMATION MAY BE USED AND/OR DISCLOSED FOR THE FOLLOWING PURPOSES :(YOU MUST EITHER STATE THE PURPOSE OF YOUR REQUEST, OR YOU MAY INDICATE "AT MY REQUEST")

PURPOSE: *LAW SUIT*

THIS AUTHORIZATION WILL EXPIRE IN 60 DAYS OR ON THE FOLLOWING (FILL IN THE DATE OR THE EVENT BUT NOT BOTH)

DATE: _____ *EVENT:* *CASE SETTLEMENT*

I acknowledge, and hereby consent to such, that the released information may contain alcohol and drug treatment records, mental health treatment records, and HIV testing, HIV results or AIDS information.

I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department.

I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and the facilities of Broward Health will not base my treatment, payment or eligibility for benefits or whether or not I provide authorization for the requested use or disclosure. I understand that the recipient may be prohibited from disclosing substance abuse information. I understand that I may inspect or copy the information to be disclosed, as provided in CFR 164.524 (with a reasonable charge)

I understand that information used or disclosed pursuant to his authorization may be subject to re-disclsoure by the recipient of the information and is no longer protected by federal confidentiality laws.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ *Date*
Signature of Patient/Personal Representative

_____ *Relationship to Patient*
Print name of Patient/Personal Representative

DL #

COUNTY _____
STATE *Florida*

SUBSCRIBED AND SWORN BEFORE ME, THIS _____ *DAY OF* _____, *2013.*

*NOTARY PUBLIC*_____
NOTARY STAMP

MY COMMISSION EXPIRES:

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