AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

NAME:____

DATE OF BIRTH: _______________________________ S.S. NUMBER: _________________________________

1. I authorize the Law Office of Bruce D. Schupp, its employees, representatives, retained/consulting experts and assigns, the use or disclosure of my health information as described below.

2. The following individual(s) or organization(s) are authorized to make the disclosure:

____ ____

____ ____

____ ____

3. The information to be used or disclosed is as follows: Copies of the entire hospital and medical records regarding the treatment of the above referenced individual including, but not limited to, records, reports, handwritten notes, memorandum, correspondence, nurse's notes, physician's orders, operative reports, pain questionnaires, histories, in-take sheets, laboratory results, laboratory reports, pathology reports, toxicology reports, consultation reports, discharge summary, and all diagnostic reports and films, including x-rays, MRI films, CT scans, and discography films. Also include all itemized billing statements for services rendered for the dates of services listed

4. This information identified above may be used by or disclosed to the following individual(s) or organization(s):

Name: The Law Office of Bruce D. Schupp
Address: 1140 N Town Center Drive, Suite 100
Las Vegas, Nevada 89144-0605

5. This information for which I am authorizing disclosure will be used for the following purpose(s): My personal records, sharing with other health care providers as needed, and litigation.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. I understand that treatment, payment, enrollment or eligibility for benefits is not conditioned on the signing or failure to sign this authorization or release or refusal to release my personal health information.

8. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

9. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

10. Please be advised that, pursuant to the provisions of N.R.S. 629.061, you are limited to a maximum charge of $.60 cents per page for any copies provided pursuant to this authorization and consent.

11. This authorization will expire at the conclusion of the underlying claim or five years from the executed date below.

You are authorized and instructed to accept a photocopy of this signed authorization in the place and stead of the executed original.

Dated this ________ day of _____________________, 20______.

✘ ____