HIPAA AUTHORIZATION - RELEASE OF PROTECTED HEALTH INFORMATION

Patient's PRINTED Name:	Birthdate:	Social Security Number:	Contact Phone No.:

I hereby authorize the use/disclosure of health information about me as described below. I hereby authorize the health care providers, physicians, hospitals, clinics and institutions, medical facilities, mental health clinics, mental health hospitals, pharmacies and/or other medical professionals in receipt of this authorization to disclose records obtained in the course of my evaluation and/or treatment to the class of person presenting this release to you as detailed below via [ ] personal courier [ ] facsimile [ ] mail.

CLASS OF PERSONS TO WHOM PROTECTED HEALTH INFORMATION MAY BE RELEASED:

Sage Adjusting LLC, and its affiliated companies, Signal Mutual Indemnity Association, Signal Administration, Inc. and/or court reporting service or records service company and any attorneys representing the Defendants named/to be named in the referenced lawsuit presenting this authorization.

TYPE OF ACCESS REQUESTED: Copies of Records and pathology slides, tissue samples, x-ray films/films of any kind, computer stored images, and any test or procedure results (however maintained) for all time periods past until two years from the date of this authorization.

DESCRIPTION OF RECORDS OR SLIDES/SAMPLES/FILMS/IMAGES REQUESTED: ENTIRE RECORD, including, but not limited to, the following categories of records: Discharge Summary, Emergency Room Records, History and Physical Records, Consult Report(s). Operative Report(s), Rehab Services, Laboratory Reports, Imaging/Radiology, Nursing notes, Medication Record, Psychological Record, Psychiatric Record(s), Progress Notes, Physician Orders, Pathology Report(s), Cardiopulmonary Report(s), Face Sheet(s), Inpatient Treatment, Outpatient Treatment, Emergency Room Treatment, Clinical Chart(s), Clinical Report(s)/Document(s), Correspondence, Test Results, Questionnaires/Histories, Doctor's Handwritten Notes, documents received by other physicians, Autopsy Report(s), Histology Reports, Cytology Reports, CT Scans, MRI, Echocardiogram Reports, Echocardiogram Videos, Cardiac Catheterization Reports, Cardiac Catherization videos/CDs/films/reels, Mammograms, Myelograms, Pharmacy Prescription records including NDC numbers and drug information handouts/monographs, Information regarding alcohol/substance abuse, consent forms, Medical Power of Attorney, Advance Directives, organ donation records, requests to amend records, log sheets, demographic information, nuclear medicine reports, ultrasound reports/videos/pictures, and Billing Records including all statements, itemized bills and insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided and other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, etc.).

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

This authorization is given in connection with pending claims and is valid and shall be honored by the health care provider for the entire time that claims remain pending in the referenced lawsuit. The party receiving information pursuant to this authorization is notified that the authority to use such authorization terminates when the lawsuit has concluded as to all parties.

I understand that :

1. The records used/disclosed pursuant to this authorization may include information relating to Human Immunodeficiency Virus ("HIV") or Acquired Immunodeficiency Syndrome ("AIDS"), treatment for or history of drug or alcohol abuse, or mental or behavioral health or psychiatric care.
2. Information disclosed by this authorization may be re-disclosed by the recipient of your Protected Health Information. Such re-disclosure will no longer be protected by this authorization.
3. I understand that I have a right to cancel this authorization at any time. If I wish to cancel this authorization, I understand that I must do so in writing and give it to the Medical Records Department of the medical facilities where I have been treated and/or evaluated or to the party/class of persons requesting the above-specified protected health information. I understand that cancellation will not apply to information that has already been released based on this authorization.
4. I have the right to receive a copy of this authorization. Copy of the authorization received. _____ (Initials)
5. A copy or facsimile (fax) of this authorization **IS** as valid as the original.
6. My healthcare and the payment of my healthcare will not be affected if I refuse to sign this authorization.
7. This authorization is intended to comply with all release of information requirements mandated by HIPAA and/or federal law.

I have read the above/had it read to me and authorize the disclosure of the Protected Health Information.

SIGNED:_____ **DATE:** _____

Signature of Patient/Legal Guardian or Representative*

_____ **WITNESS:**_____

(Relationship, if signed not signed by patient)

Representative must submit copies of legal document supporting his or her authority to act on the patient's behalf.