AUTHORIZATION TO DISCLOSURE HEALTH INFORMATION
IN COMPLIANCE WITH HIPAA 164.508

Patient Name: _____
Date of Birth: _____ SSN:_____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized the disclosure:

   _____

3. The type and amount of information to be used or disclosed is as follows: **entire record.**

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may contain include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclose to and used by:
   Attorney: **ROBERT J. WAGONER CO., L.L.C.**
   445 HUTCHINSON AVENUE, SUITE 100
   COLUMBUS, OHIO 43235
   For purpose of: **Representing my legal interests.**

6. I understand I have the right to revoke this authorization any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the rights to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, **this authorization will expire in six months.**

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I know that I can contact your facility.

_____ Date _____
Signature of patient or legal representative

_____
If signed by a legal representative,
relationship to patient