

Authorization To Disclose or Use Protected Health Information

I, hereby authorize Blackburn Group, Inc., 6709 Glenkirk Road, Baltimore, MD. 21239-1411, (443) 841-5255 to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Patient Full Name: _____
Social Security Number: _____
Patient's Address: _____
Date of Birth: _____
Medicare Card Number (If Applicable): _____

Information to be disclosed to: **Blackburn Group Inc.**
6709 Glenkirk Road
Baltimore, MD. 21239-1411

Disclose the following information for all treatment dates from beginning to present including:

Complete Medical Records	Laboratory	
Consultations	Outpatient Reports	
Discharge Summary	Pathology	
Emergency Reports	Physical Therapy	
History & Physical	X-ray	Other Specified: _____

The above information is disclosed for the following purposes:

Medical Care Legal Insurance Personal Other _____

1. I understand I may revoke this authorization at any time by requesting revocation of the information of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.
2. HIPAA DISCLOSURE—I have been fully advised of my rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and I intend for this authorization to satisfy the requirements of HIPAA and the rules and regulations relating to that Act. In that regard, I certify that I consent to the release of my records to my attorney, that the purpose of this request is for my attorney to assist me in my legal claim, and that the release of my entire medical record is the minimum disclosure necessary to satisfy this request.
3. This authorization expires on _____ (date provided by patient.)

4. _____ Signature of Patient or Legal Representative	5. _____ Date
_____	Self _____
Printed name of patient or patient's representative	6. Relationship to patient or authority to act for patient

A photocopy of this authorization is as good as an original.