# Authorization To Disclose or Use Protected Health Information

I hereby authorize Blackburn Group, Inc., P.O. Box 142, Penfield, NY 14526, (585) 586-4530, along with any health care facilities/providers, treating physicians, health insurance payers, pharmacies, and the Centers for Medicare and Medicaid Services 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.**
**P.O. Box 142**
**Penfield, NY 145263**

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

| | | |
|---|---|---|
| Complete Medical Records | Laboratory | |
| Consultations & X-rays | Outpatient Reports | |
| Discharge Summary | Pathology | |
| Emergency Reports | Physical Therapy | |
| History & Physical | Pharmacies | 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 written notice to Blackburn Group, Inc. and any of the above referenced hospital/physician practices 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 and Blackburn Group, Inc., that the purpose of this request is 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 upon of completion of all applicable and requested items to satisfy my insurance claim under the law.

4. _____ **Signature of Patient or Legal Representative**

5. _____ **Date**

_____
**Printed name of patient or patient's representative**

6. **Self**_____ Relationship to patient or authority to act for patient

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