**AUTHORIZATION TO RELEASE INFORMATION**

TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Re: Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I hereby authorize and request the above-named source to disclose my medical and other records and legal and government records and to provide any information requested concerning me to my attorney, David A. Valerio, Esquire, or my attorney's representative.

2. I specifically authorize my attorney, David A. Valerio, Esquire, or my attorney's representative, to receive any records or information concerning (Please check applicable boxes):

[ ]  Psychological or psychiatric illness

[ ]  Drug or alcohol abuse

[ ]  Sickle cell disease

[ ]  Results of HIV tests

[ ]  AIDS

[ ]  Medical records including hospital and emergency room reports,

 Doctor’s notes, X-ray, laboratory, and other reports and billings

[ ]  Law enforcement and/or DMV records

[ ]  Admission and Discharge summary

[ ]  Other information requested by my attorney

Please send requested records to:

David A. Valerio, Esquire

P.O. Box 4977

Auburn, CA 95604

3. My attorney, David A. Valerio, Esquire, may use these records for the purpose assisting me with my legal matters.

4. I hereby acknowledge that the doctrine of informed consent has been explained to me and that I understand the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information including the Health Insurance Portability and accountability Act of 1996 (“HIPAA”).

5. I hereby acknowledge that this authorization to release information and PHI is voluntary and is valid until fulfilled. I further acknowledge that I may revoke this authorization at any time except to the extent that action based on this authorization has been taken. Unless and until revoked by me by written notice to David A. Valerio, Esquire and the above-named provider of records or information this authorization shall be valid for one year from the date above.

1. A copy of this Authorization is as valid as the original.

7. I understand the potential for information provided under this release to be re-disclosed but agree to such re-disclosure solely for the purpose of pursuing and/or resolving my case.

8. I acknowledge I have the right to receive a copy of this authorization.

9. This Authorization is effective immediately and shall be valid for one year from the date of signature unless a different date is specified here - 12/31/2024.

Date Signed:\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Client Signature