AUTHORIZATION FOR RELEASE OF MEDICAL, PSYCHOLOGICAL AND COUNSELING RECORDS

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____
(NAME AND ADDRESS OF PROVIDER)

_____ to

release health care information of the patient named above to:

1. Name: _____

   Address: _____

   City: _____ State: _____ Zip Code: _____
2. The photocopy service retained by the person or entity listed as #1 above;
3. The persons or entities against whom the undersigned is making the claim; and
4. The insurance carrier of the persons or entities against whom the undersigned is making the claim

This request and authorization applies to the disclosure of psychiatric, psychological or other confidential records to my emotional or other psychiatric/psychological condition, including substance abuse (including drug and alcohol information) for the purpose of review and evaluation in connection with a legal claim.

¨ Psychological/Counseling records relating to the following dates: _____

_____

¨ All Psychological/Counseling records

Specify Records to be Disclosed:

All psychiatric/psychological records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondences, test results, statements, questionnaires/histories, therapy notes, office and doctor's handwritten notes, records received by other physicians, pharmacy and prescription records and billing records, Insurance claim forms and insurance reports.

• I understand that this authorization is voluntary. I understand that that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization.

• I understand I have a right to a signed copy of this authorization.

• Copies of this authorization will be considered as valid as the original.

• I acknowledge the right to revoke this authorization in writing to: _____at

_____. However, I understand that any actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

• I understand that once disclosed, there is a potential for unauthorized re-disclosure and the information may not be protected by state or federal confidentiality rules.

• By this authorization, the undersigned specifically waives the provisions of Section 5328 of the Welfare and Institutions Code. 42 CFR, Part 2 of the Federal Regulations and Evidence Code Section 1015.

• This authorization shall become effective immediately and shall remain in effect until_____or for one year from date of signature.

If this authorization is being signed by a personal representative on behalf of a patient, please provide name and describe relationship to patient or authority to execute this authorization.

Signature: _____ Date Signed: _____

Name of Personal Representative: _____ Authority or Relationship to Patient: _____

Authorized Agent:
Knox Attorney Service, Inc./ Knox Services LLC.

Authorized Agent:
Knox Attorney Service, Inc./ Knox Services LLC.