AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION IN COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) REGULATIONS

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

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

2. The following individual(s) or organization(s) are authorized to make the disclosure:
   _____

   _____

3. The type of information to be used or disclosed is as follows:
   COMPLETE MEDICAL RECORDS AND ITEMIZED ACCOUNT STATEMENTS.

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 also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. The information identified above may be used by or disclosed to the following individuals or organization(s) My Attorneys -
   Office (415) 326-4807, Fax (415) 534-3450:

   Law Offices of Michael H. Panah
   21 Orinda Way, Suite C158
   Orinda, CA 94563

6. The information for which I'm authorizing disclosure will be used for my Personal Injury litigation.

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire One (1) year from the date on which it was signed.

9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

11. I have the right to receive a copy of this Authorization.

Signature of patient or legal representative: _____

Printed Name: _____

Date: _____, 20____.