Client Authorization Forms

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Operation PAR, Inc.

Medical Records Department · 6720 54th Avenue North · St. Petersburg · FL 33709 · Phone: 727-545-7544

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION – GENERAL

I, ______________________________ (Client Name), DOB:________ SS# __________ PH# __________

Authorize Operation PAR, Inc., to disclose to: (Provide Name and Address) RECORDS DEPOSITION SERVICE, INC.
P.O. BOX 5054, SOUTHFIELD, MI 48086-5054
P: 248-357-3330 F: 248-357-3337

The following information: *Note: Draw a line through information not needed.*

Assessments, History and Physical, Medication Administration Records, Treatment Plan, Progress Notes, Lab Results, Discharge Summary and Continuing Care Plan, Other PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST FOR INFORMATION TO BE DISCLOSED

Purpose for the disclosure--be specific: FOR DISCOVERY BEFORE TRIAL

Optional: I also agree to the disclosure of HIV Testing information and AIDS Diagnosis: ________ (Client Initials)

Information will be disclosed in writing and/or verbally. Client initial for FAX approval: ________

I understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of medical records and protected alcohol and drug abuse health information under 42 C.F.R., Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided for by the regulations.

I also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below:

Date, event or condition of expiration: ______________________________

I understand that I might be denied services if I refuse to consent to a disclosure for treatment, payment or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes. I also hereby release Operation PAR, Inc., from liability which may arise as a result of information disclosed under an authorization, if such information disclosed is later used to my detriment.

Date: ________ Signature: ______________________________ (Client Signature)

Date: ________ Signature: ______________________________ (Witness)

Date: ________ Signature: ______________________________ (Authorized Representative) ______________ (Legal Authority to Act)

For Office Use: Authorized information released by: ______________________ Date released: __________

Information released: ______________________________

(PAR # 2101A 5-05)