HIPPA AUTHORIZATION FOR MEDICAL INFORMATION
(Pursuant to 45 C.F.R. sections 160-64)

PATIENT : ____________________

D.O.B. : ____________________ S.S. #: ____________________

DATES OF SERVICE : ____________________

PROVIDER : ____________________

____

____

You are authorized to release medical information to:

THE PROFETA LAW FIRM, P.A.
150 S.W. 27th Avenue
Miami, FL 33135

This authorizes the physicians, hospitals and all medical attendants to furnish full and complete medical reports, itemized billing and information hereby requested by the undersigned, to my attorneys, THE PROFETA LAW FIRM, P.A., or to any representative or investigator of said firm. This authorization also includes examination of all hospital records, including records concerning Mental Health, Psychological/Psychiatric reports, HIV, Drugs and Alcohol, x-ray film and/or MRI films and furnishing of any information, including opinions, written or oral, bills to my attorney for use in a pending legal matter.

I understand I have the right to revoke this authorization and if I choose to do so, I will notify the provider in writing. Unless I so choose, this authorization expires one year from the date shown below.

I understand that treatment and payment may not be conditioned on obtaining this authorization, and I acknowledge that signing this form will not result in a denial of healthcare.

I understand that there is potential for my medical information to be re-disclosed.

Pursuant to the Health Insurance Portability and Accountability Act of 1996, I further request that all of my protected health information, including any medical logs pertaining to the release of my protected health information, to whom it was sent, why and when, also be furnished to THE PROFETA LAW FIRM, P.A.

A photocopy of this authorization may be recognized in lieu of the original.

Your full cooperation with my attorney is requested. You further requested to disclose no information to any other persons without written authority to do so.
ALL PRIOR AUTHORIZATION IS HEREBY CANCELLED. THIS AUTHORIZATION EXPIRES *ONE YEAR FROM THE DATE SHOWN ABOVE.*

____________________ ____________________
PATIENT DATE