HIPPA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:	Social Security Number:	Birth Date:

I hereby authorize _____to release and disclose Protected Health Information about me to **Susan. P. Pniewski, Esquire.** "Protected Health Information" or "PHI" includes any information that relates to (1) My past, present or future Physical or mental health or condition; or (2) Health care I have received or will receive; or (3) Payment for health care I have received or will receive.

The following information to be disclosed:

[ ] All information maintained by you (including records prepared by others that are in your possession) regarding the above listed patient.

Or only the following:

[ ] Health Treatment [ ] Dental Treatment [ ] Vision Treatment
[ ] Other _____
[ ] Records related to the following treatment: _____
[ ] Related to the following time period(s):_____to_____

I understand that the records to be disclosed pursuant to this Authorization may contain records or information relating to treatment or participation in the following:
Federally assisted drug or alcohol abuse problems
HIV Testing or HIV or AIDS Status
Diagnosis and Treatment of Mental or Psychological Health
I understand that such information is subject to special protections pursuant to state and federal laws. By my initials, I authorize the use or disclosure of such records if they are otherwise included within the scope of this Authorization.
I understand that I have the right to revoke this Authorization in writing, except to the provider has taken action in reliance upon this Authorization. I understand that I may see and copy the information described on this form if I ask for it, and that I may obtain a copy of this form after I sign it. I understand that this Authorization is voluntary and that I may refuse to sign this Authorization. My refusal to sign will not affect my ability to receive treatment.

I understand that my Protected Health Information will be used or disclosed for purposes of responding to the lawsuit or claim brought by me or involving me. I understand that my PHI may be made available to various parties also involved with or defending such legal action by me or involving me, and that the information, once disclosed, might no longer be subject to certain state or federal privacy protections once released.

This Authorization expires on the earlier of _____, 2008 or the following event: _____, but such expiration will not be effective as to records already released in reliance of the Authorization.

_____

Signature of Patient or Personal Representation Date

Personal Representative Section

If a Personal Representation executed this form, that Personal Representative warrants that he or she has authority to sign this form on the basis of:

Legal Authority (Power of Attorney, etc.) Please attach evidence.
Parent, Guardian or other individual acting in loco parentis
Written Designation by the Patient.