Law Office of Gabriel J. Christian & Associates, LLC
3060 Mitchellville Road, Suite 216
Bowie, Maryland 20716
(301) 218-9400 Office. (301) 218-9406 Fax

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HIIPPA AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

This will authorization you to release to the office of the above attorney or any agent thereof all medical records of whatever nature, including but not limited to billing statements, mental health records, radiology films, pathology material, photographs, videotapes, and other information, concerning:

NAME OF PATIENT: _____

PATIENT'S SOCIAL SECURITY NO.: _____

PATIENT'S DATE OF BIRTH: _____

DATE OF FIRST TREATMENT: _____

This will also authorize you to speak with and to disclose orally any information relating to any diagnosis, care, treatment, prognosis, and opinions with regard to the above patient to office of the above attorney or any agent thereof.

The purpose of the release and disclosure of this information is at the request of the individual.

I understand that I may specify a date for the expiration of this authorization, but that it shall expire by law without my express revocation, one year from the date written below, or on _____. *I understand that I may revoke this assignment in writing*. Revoking this authorization will not have any effect on actions that the health care provider took in reliance on the authorization before the health care provider received notice of the revocation. The information to be disclosed may be protected by law. Information disclosed pursuant to this authorization may be redisclosed by the recipient and no longer protected by federal privacy regulations. I understand that my ability to receive health care treatment from the health care provider will not be affected if I do not sign this form. However, without my signature this request to release the information described above will not be honored. The protected health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases (including HIV/AIDS) and/or genetic marker information. These records will be included in the information we will make available to the individual or organization I have identified above.

_____ _____

Date Client's Name

Note to Health Care Providers: This authorization is provided in compliance with HIPAA. Failure to forward requested information may render a health care provider liable for damages.

A PHOTOCOPY OF THIS AUTHORIZATION MAY BE USED IN LIEU OF THE ORIGINAL.