Authorization for the Disclosure of Protected Health Information

Pursuant to the Privacy Rule regulations promulgated under the Health Insurance Portability and Accountability Act ("HIPAA"), I hereby authorize the disclosure of my protected health information as described below. This authorization is provided to you voluntarily and at my request.

Name:_____ Date of Birth:_____

Social Security Number:_____

The purposes of the requested disclosures are as follows. The disclosures permitted pursuant to this Authorization are solely for purposes of litigation in the case styled _____ _____ (referred to in this Authorization as the "Litigation").

The persons or classes of persons authorized to provide information pursuant to this Authorization are:

(a) The Custodian of Records, physicians, therapists, counselors, and others who may have been involved in the care or treatment of _____
on behalf of _____.

(b) The Custodian of Records, physicians, therapists, counselors, and others who may have been involved in the care or treatment of _____on behalf of _____ _____.

The persons or classes of persons authorized to receive information pursuant to this Authorization are:

(a) Paul M. Deutsch & Associates, P.A., Paul M. Deutsch, Ph.D., and employees of Paul M. Deutsch & Associates, P.A. who are engaged in work in the Litigation under the supervision and control of Paul M. Deutsch & Associates, P.A., including but not limited to assistants, secretaries, and clerical employees.

(b) Attorneys of record in the Litigation, their partners or associate attorneys assisting attorneys of record who are engaged in work in the Litigation under the supervision of counsel of record including, but not limited to, paralegals, assistants, secretaries, couriers, stenographic and clerical and staff employees.

(c) Experts or other witnesses identified, consulted or retained by _____ or any other party to the Litigation.

(d) Other persons, organizations and/or entities directly connected with the Litigation including, but not limited to, the court, court reporter(s), copy services and others.

A specific description of the information authorized for disclosure pursuant to this Authorization includes:

All information and documentation (including notes, summaries and records of any kind, including electronic and hard copy information and documentation) in your possession, or under your control, and testimony under oath, relating to health care provided to:
Name:_____
D.O.B.:_____ S.S. #:_____,
including but not limited to examinations, symptoms, evaluations, treatment, opinions, diagnosis, prognosis, progress, medication, prescriptions, monitoring, x-rays, MRI's, CT's, results of clinical tests, hospitalization, office records and billing statements.

Unless revoked sooner, this Authorization shall expire at the conclusion of the Litigation.

I understand that the protected health information described above may be subject to re-disclosure by the recipient and will no loner be protected by the HIPAA privacy rule regulations. Therefore, I release the disclosing person, its workforce members and its contract representatives from all liability arising from the disclosure of my health information pursuant to this Authorization.

I understand that I may revoke this Authorization at any time by notifying you in writing, except to the extent you have taken actions in reliance on this Authorization prior to receiving notice of the revocation.

I understand that I may refuse to sign this Authorization and that my refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits.

Signature of Client:_____ Print Name:_____

Signature of Parent/Legal Guardian:_____

Date:_____