LIMITED AUTHORIZATION FOR RELEASE AND* DISCLOSURE OF HEALTH INFORMATION

The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure is:

[DEFENSE COUNSEL NAME PLACED HERE]

PATIENT NAME: [PATIENT NAME PLACED HERE]

DATE OF BIRTH: [DATE OF BIRTH PLACE HERE]

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, to the following recipients: for the purpose of: **"LITIGATION"**.

THIS AUTHORIZATION IS LIMITED, however, to the furnishing of **existing records only**, and is **not** to be construed as an authorization permitting you to prepare written reports or **orally discuss, disclose or render any opinions** concerning any records, health information or prognosis relating to the above-named patient with the attorneys who are requesting those records, or anyone acting on behalf of those attorneys. Further, this authorization **does not permit** you to furnish any records concerning conversations or communications with the above-named patient's attorneys, Powers & Santola, LLP, or their representatives, or to orally discuss or disclose such conversations or communications.

The type and amount of information to be used or disclosed is as follows: The complete medical record/chart of the above-named patient and all materials or information including, but not limited to, all medical records, hospital records, physicians' records, surgeons' records, consultation records, operative reports, physical therapy and other therapy records; x-ray, CT scan, MRI, PET scan and reports or other diagnostic studies; laboratory reports; patient information and history questionnaire; physicals and history; discharge summary; progress notes; prescriptions and medication records; nurses' notes; psychotherapy notes, correspondence; consent for treatment; statements for services rendered; or any other materials (whether written or stored, created or maintained in any other form) relating or pertaining to this patient, including documents and records received from or that were created by another provider.

I understand that the information in the patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse.

This authorization shall remain in full force and effect until it **expires one year** from the date set forth below.

I understand that I have the **right to revoke this authorization** at any time. I understood that if I revoke this authorization I must do so in writing by sending or presenting my written revocation to the Privacy Contact of the health care provider named above. I understand that the revocation of this authorization will not apply to the extent that the health care provider has taken action in reliance thereon; or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to consent a claim under the policy or the policy itself.

* This is a records only authorization, and does not constitute an *Arons* speaking authorization.

I understand that authorizing the disclosure of this health care information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 C.F.R. § 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of the patient's health information by the recipient, resulting in the health information no longer protected by federal or state confidentiality rules.

Dated: [INSERT DATE]

_____

[CLIENT NAME]

STATE OF NEW YORK)

) ss.:

COUNTY OF)

On the _____ day of _____, _____, before me personally came [CLIENT], to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me the execution thereof.

_____

Notary Public