Authorization for Release of Information

Complies with HIPAA Section 164.508

Form type: Employment

I, **Name:**
SSN:
DOB:
Address (optional):

HEREBY AUTHORIZE:

Custodian Name:
Address:

THE USE AND/OR DISCLOSURE OF INFORMATION TO:

Attorney Name:
Firm Name:
Address:

BY AND THROUGH **INDIANAPOLIS LITIGATION SUPPORT GROUP**, 120 E. MARKET, INDIANAPOLIS, IN 46204

FOR THE PURPOSE OF: LITIGATION/LEGAL PROCEEDING

PLEASE RELEASE THE FOLLOWING INFORMATION:
A completed affidavit with a copy of any and all employee and personnel records, including but not limited to, memoranda, rate of pay, applications, job description, references, training completed, awards, reprimands, attendance, sick leave, doctor notes, insurance records, benefits and Workers' Compensation records, performance reviews, letters, correspondence, payroll and W-2 forms.

-- I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance to this consent by sending written notice to the custodian listed at the above address.
-- I understand the information described above may be redisclosed by the recipient and, in such case, would no longer be protected by the federal Privacy Rule.
-- The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

This Authorization expires (60) days from the date of signature below. Once received, the Authorization is otherwise valid until the request is completed.

A copy of this Authorization shall be considered as valid as the original.

_____ _____
(Date) (Signature)

_____
(Personal Representative/Relationship to Person Represented)
If signed by a representative, please attach a statement of authority to do so.