Authorization for Release of Medical & Billing Information

Indylsg

Complies with HIPAA Section 164.508

Name:

SSN:

Address, City, State, Zip (optional):

DOB:

HEREBY AUTHORIZE:

Custodian Name:

Address, City, State, Zip:

THE USE AND/OR DISCLOSURE OF INFORMATION TO:

Attorney & Firm Name:

Address, City, State, Zip:

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:

1. A completed affidavit with a copy of any and all legal medical chart records (all office records) of any kind (physical or electronic), including but not limited to, reports, notes, memoranda, patient file materials, radiology reports, records of consultations, prescriptions, treatments and diagnosis regarding any physical and/or mental condition, illness or injuries, including all notes, memoranda, questionnaires and intake forms, letters and reports in your possession prepared by any other health care provider

1. (Date Range)

2. Any and all billing and patient account records, including but not limited to, any and all Explanation(s) of Benefits, itemized billing statements, HCFA/UB, Master List, and any and all write-offs and insurance payments (required in order to honor any liens)

2. (Date Range)

- [ ] 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.

(Signature)

(Date)

(Personal Representative/Relationship to Person Represented) Please state under what authority you are acting.

HIPAA Compliance. If this Contract involves services, activities or products subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Contractor covenants that it will appropriately safeguard Protected Health Information (defined in 45 CFR 160.103), and agrees that it is subject to, and shall comply with, the provisions of 45 CFR 164 Subpart E regarding use and disclosure of Protected Health Information.

HIPAA COMPLIANT