LAW OFFICES OF

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**A PROFESSIONAL LIMITED LIABILITY COMPANY**

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# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, ________________________________________, hereby authorize use or disclosure of protected health information about _____________________, a minor, as described below:

**Information to be released from:**

**PROVIDER:** ________________________________________________________

**Information to be released to:**

Kornfeld Trudell Bowen & Lingenbrink, PLLC, Attorneys at Law, and/or any associates of said attorney at the address listed above.

**Information to be released:**

All medical records and billing statements, including all clinical or hospital records in full. This includes but is not limited to: X-rays, diagnostic testing of any nature, laboratory tests, correspondence, notes, written records, or written documents of any nature.

**Purpose for which disclosure is being made:**

[X] Attorney [ ] Insurance [ ] Doctor [ ] Personal

**Patient Authorization:** I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. *I give my specific authorization for these records to be released.*

**My Rights:** I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I may revoke this authorization in writing. However, I understand that any action has been taken in reliance thereof cannot be reversed and my revocation will not affect those actions; and unless earlier revoked, this authorization shall expire within 90 days from the date of this release.

______________________________ ______________________________
Dated Parent and/or Guardian