

THE SALAZAR LAW FIRM, P.A.  
1408 S. Andrews Ave., FT. Lauderdale, Florida 33316  
TELEPHONE: (954) 467-1965 - FAX: (954) 467-1760

AUTHORITY TO RELEASE MEDICAL INFORMATION

TO:

Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Approximate date(s) of service: \_\_\_\_\_

I, the undersigned patient, authorize the above-named health care provider to release my health information indicated below to my attorneys, THE SALAZAR LAW FIRM, P.A., 1408 South Andrews Avenue, Ft. Lauderdale, FL 33316, for the purpose of representation in a personal injury action. The type and amount of information to be disclosed is as follows:

\_\_\_\_\_ Itemized bill for services (payments not reflected)

\_\_\_\_\_ Itemized bill showing payments made to date

\_\_\_\_\_ Medical reports to date

\_\_\_\_\_ Complete Hospital Record

\_\_\_\_\_ Abstract of Hospital Record

\_\_\_\_\_ Emergency Room Report only

\_\_\_\_\_ Other:

I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken pursuant to this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health care provider named above. I understand that authorizing the disclosure of this health care information is voluntary. I can refuse to sign, and the health care provider will not base my treatment, payment or eligibility for benefits on whether or not I provide authorization for the requested use or disclosure. I understand that the recipient may be prohibited from disclosing substance abuse information. I understand that I may inspect or copy the information to be disclosed, as provided in CFR 164.524 (with a reasonable charge). I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by the federal confidentiality laws. I understand that the provider will release only the minimum amount of information necessary to fulfill a request.

Unless otherwise revoked, this authorization will expire six months form the date of the signature listed below.

Date \_\_\_\_\_

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Witness