Carolina Rehabilitation Consultants

HIPAA DISCLOSURE & AUTHORIZATION TO DISCLOSE CONFIDENTIAL MEDICAL, VOCATIONAL, EDUCATIONAL, EMPLOYMENT, AND CLAIM INFORMATION

Full Name: _____

Date of Birth: _____ Social Security Number:_____

I hereby authorize the disclosure of my confidential **medical records and medical billing/statements** from **any and all** medical facilities, hospitals, doctors' offices, diagnostic/testing and radiology facilities, vocational, educational, employment and claim information and records, as outlined below, to be provided to **Carolina Rehabilitation Consultants, LLC**. The information requested is hereby authorized to be released **electronically by email to carolinarehabconsultaants@gmail.com.**

(a) **Medical Records:** Any and all medical records (*written or electronic*,) to include, but not be limited to, all intake and/or history forms, hospital admissions records and summaries, office and/or narrative notes, opinions, assessments, psychological testing/results, incident reports, test results, medical records and/or narratives, x-rays, CT Scans, MRI's, nerve conduction studies, doctor's notes, handwritten statements of patient, reports, patient questionnaires, information, diagnostic testing, computer print-outs, correspondence, notes and charts, as well as all correspondence, emails, forms, faxes, notes or documentation of any kind, provided to, or received from any insurance carrier(s) and/or nurse case manager(s), attorneys, employers, or otherwise, related to my care and treatment.

(b) **Employment and Personnel Records**: Any and all records (*written or electronic*,) to include, but not be limited to, applications for employment, resumes, personnel records, job descriptions, performance evaluations, promotions, commendations, awards, or disciplinary records, payroll records, health or medical insurance information, drug screens/results, work excuses, work restrictions, attendance records, termination records, grievances, tax information, incident report(s), witness statements, and a complete copy of any and all investigative reports, videos, photos, and/or recordings of any kind.

(c) **Vocational/Educational & Psychological Records:** Any and all records (*written or electronic*,) to include, but not be limited to, school transcripts, test results, psychiatric/psychological evaluations and records, IQ tests, standardize test results, counseling records, disciplinary records, attendance records, evaluations, and placement plans for learning disabilities.

HIPAA DISCLOSURE

I acknowledge I have been fully advised of my rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R., Section 164.508. I further understand that this Authorization is executed "at the request of the individual" for the purpose of legal proceeding(s), and that the Protected Health Information is being released for purposes related to that matter. I also understand that the Protected Health Information may be subject to state and federal law, but I expressly authorize the release of such information as specified herein. I understand that once this information is released, the medical provider(s) can no longer control or be responsible for its use or re-disclosure. Once released, the information may no longer be protected under HIPAA. I understand that I have the right to revoke this authorization at any time, except to the extent that my medical providers have taken action in reliance upon it. I further understand if I revoke this authorization I must do so in writing and present my written revocation to the provider(s). I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

*I understand, unless otherwise revoked, this authorization will expire within **three (3) years** from the date herein, or at the end of legal representation. If I fail to specify an expiration date, event or condition, this authorization will expire in thirty-six (36) months. I further understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the party to whom this authorization is being provided.*

You are requested to treat such information as confidential and are not authorized to release, disclose, or discuss any information released to any insurance adjuster, attorney, nurse case managers, representative, or anyone else without written authorization from my attorney(s) or me. This does not prohibit the filing of medical insurance, Medicare/Medicaid Applications, or forms on my behalf.

_____ _____

Signature Witness

_____ _____

Printed Name Date

A photocopy of this form shall have the same force and effect as the original.