

I may revoke this authorization at any time, but I must do so in writing and submit it to the facility or doctor holding the records as listed on this form. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

Purposes for which the information will be used or disclosed.

_____ Personal (at request of patient)	_____ New Physician
_____ Primary Care Physician	_____ Social Security Disability
_____ Medical Insurance Claim	_____ Life Insurance
_____ Workers' Comp Attorney	_____ Other _____

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I have a right to receive a copy of this authorization.

THIS AUTHORIZATION WILL EXPIRE UPON ITS COMPETITION OR THREE MONTHS FROM THE DATE OF SIGNATURE, WHICHEVER COMES FIRST

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by state law and may no longer be protected by federal confidentiality law (HIPAA).

Patient's Name

Patient's Signature

Legal Guardian Name

Legal Guardian signature

Date

Date

Fax: 888-850-5101
request@retrievalsupport.com