HIPAA
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name ______________________________

List all names used

Date of Birth ____________________ **Social Security Number** ____________________

I hereby authorize the use or disclosure of the above-named individual's health information as described below:

Information to be released from: ______________________________

Name of designated Facility or Provider

____

Address, City, State, Zip

Information to be sent to: **Lexitas**
307 29th St NE, Ste 101
Puyallup, WA 98372-6718
Phone: 253-445-3400 § Fax: 253-445-4425
warecords@lexitaslegal.com

Information to be disclosed:

- ☐ Entire Medical Record
- ☐ Entire Medical Record from ____________ (*Date*) **To** ____________ (*Date*)
- ☐ All Itemized Billing Statements & CPT Codes
- ☐ All Itemized Billing Statements & CPT Codes from ____________ (*Date*) **To** ____________ (*Date*)
- ☐ All Films/X-rays/MRIs
- ☐ All Films/X-rays/MRIs relating to ______________________________
- ☐ Other ______________________________

Purpose for which disclosure is being made: *(Please check one of the following)*

☐ 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. **Exclude** the following information from the records released; (Please initial)

________ Drug/Alcohol abuse/treatment & diagnosis ________ Sexually Transmitted Disease (STDs)

________ HIV/AIDS diagnosis/treatment/testing ________ Mental Illness or psychiatric diagnosis/treatment

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it at which time it may no longer be protected under Privacy laws.

Signature: ______________________________ Date: ____________________

(Patient, Guardian, or Authorized Representative)

______________________________	______________________________
Defendant's Attorney	Plaintiff's Attorney
Please Print Name	Please Print Name
Address	Address
City, State, Zip	City, State, Zip
WSBA# ____________	WSBA# ____________
Do you want a copy? ☐ Yes ☐ No	Do you want a copy? ☐ Yes ☐ No

This authorization will expire 90 days from the date signed

A copy of this authorization shall have the same force and effect as the original