HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECORDS

For: Pegasus Risk Management, its agents, attorneys and subsidiaries.
RE: Patient Name_________________________________DOB:___________________________
Patient Address____SS#____-____-____
To:____

I authorize and request the disclosure of all protected information to aid the above party and his/her agents, insurance companies and attorneys in establishing the liability, nature, and extent of a claim for injuries or disabilities and to establish benefits, expenses, compensation and damages. I expressly request that the designated record custodian of all covered entities under HIPAA disclose full and complete protected medical information to the organization identified above, including the following:

☐ All medical records, meaning every page in my record, including but not limited to office notes, face sheets, history and physical, consultation notes, inpatient and outpatient treatment, emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, correspondence, test results, statements, questionnaires, photographs, video tapes, telephone messages and records received by other medical providers.

☐ All physical, occupational and rehab requests, consultation and progress notes.

☐ All employment, personnel or wage records, all Civil and Criminal records, including court filings, police, prison and probation records and reports.

☐ All Medicare or Medicaid records.

☐ All Autopsy, lab, histology, cytology, pathology immunohistochemistry records and specimens, radiology records and films, NCM, MRI, CT, EMG, and cardiac cath results, videos, CDs, films, reels and reports.

☐ All school records, including, but not limited to attendance, scholastic, phys. ed, and medical notes.

☐ All pharmacy and prescription records

☐ All billing records, statements, claim forms, itemized bills, payment or denial of benefits and records of billing to third party payers.

☐ **I hereby also specifically consent to the release of any and all alcohol/substance abuse or drug records under the conditions outlined in this form.**

☐ **I hereby also specifically consent to the release of any and all psychiatric/mental health records or treatment information under the conditions outlined in this form.**

☐ **I hereby specifically consent to the release of any and all HIV medical and HIV related information under the conditions outlined in this form.**

This consent is subject to revocation by the undersigned in writing at any time by notifying the above requestor, except to the extent that action has been taken in reliance herein. If not earlier revoked, it shall terminate at the date of resolution of my claim without express revocation. I understand I have a right as a patient to review the disclosed information by requesting it from the organization providing it. I hereby release all parties from any and all legal liability that may arise from the release of this information to the party named above. This is informed consent for the release of records. A photocopy of this original shall be deemed as valid as the original.

Dated____/_____/______ SIGN HERE -> ____
Printed Name:____