AUTHORIZATION TO COPY MEDICAL RECORDS IN COMPLIANCE WITH HIPPA

Individual: _____ **AKA:** _____

Social Security Number: _____ **Date of Birth:** _____

Provider: _____

Requester: _____

Specific Information to be disclosed: This authorization directs the provider to make available for copying all records pertaining to the individual including but not limited to treatment, billing, hospitalizations, evaluations, testing, and surgeries. This includes all files or records for all injuries or conditions in Provider's possession or under Provider's control that is held for any purpose. Nothing shall be removed, deleted, altered or withheld.

Additional information to be disclosed by Provider if the box is checked:

- ☐ All billing records showing all charges, expenses, costs and payments.
- ☐ Original X-ray films.
- ☐ Drug and alcohol abuse testing, evaluation and treatment.
- ☐ Mental health information consisting of but not limited to all notes, records and reports of psychotherapy diagnosis, evaluation and treatment.
- ☐ Employment, personnel, attendance, wages, injuries, claims and disciplinary records.

No information is to be released regarding human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS).

Purpose of the requested disclosure: At the request of the Individual this information will be used for the purpose of aiding the Individual and his or her attorney in establishing the liability, nature and extent of a claim for injuries and disabilities and to establish benefits, expenses, compensation and damages. The information provided may be disclosed by the Attorney or **Scandoc Imaging, Inc.** to experts and other parties for evaluation or treatment for the purpose of prosecuting or defending any claim for which the Attorney has been engaged to pursue or defend.

Limitations on disclosure by provider: This Authorization does not permit Provider to allow the copying of the records by any other copy service or business associate as defined by the Health Insurance Portability and Accountability Act (HIPAA). This Authorization does not permit disclosure of any information to any person, entity, provider or insurance company other than the copying of the records by a representative of **Scandoc Imaging, Inc.** Any and all Authorizations signed before this Authorization is revoked.

Right to Revoke: The Individual has the right to revoke this Authorization at any time by giving the Provider written notice of revocation of this Authorization. The Individual has the right to refuse to sign this Authorization. The Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether the Individual signs the Authorization. Attorney designates and authorizes **Scandoc Imaging, Inc.** as his or her representative to pursue any and all legal remedies necessary to compel the production of records from the Provider. A copy of this signed Authorization will be given to the Individual after it has been signed.

Expiration date: This Authorization shall expire three years from the date of execution below.

A copy of this Authorization shall be as valid as the original.

Signature: _____ Date: _____

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