Cefaratti Group
THE LITIGATION SUPPORT COMPANY

HIPAA COMPLIANT MEDICAL RECORD RELEASE
45 CFR § 164.508

I _____ HEREBY AUTHORIZE _____
(Patient name)

_____
(Hospital/Doctor/Clinic name)

Patient Date of Birth: S.S.N.: _____

I authorize you to release or disclose the following protected health information about the above-named patient: (include dates where appropriate)

☐ ENTIRE MEDICAL RECORD:

☐ OTHER (as specified):

I understand that the information to be disclosed may include records relating to alcohol or drug abuse, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex (ARC), sexually transmitted disease, billing records. It may also include information about behavioral or mental health services to the individuals or organizations listed below.

I authorize you to release the information to: CEFARATTI GROUP, INC., 4608 St. Clair Avenue, Cleveland, Ohio 44103

Purpose and need for such disclosure: PRETRIAL DISCOVERY

Case Caption:

I understand that I have the right to cancel this authorization, in writing, at any time by presenting my written cancellation to: Hospital/Doctor listed above. I understand that a cancellation will not apply to information that has already been released under this authorization. I also understand that information disclosed pursuant to this authorization may no longer be subject to state or federal privacy regulations and laws.

I understand that information disclosed pursuant to this authorization may be re-disclosed to any other counsel representing any plaintiff or defendant in the lawsuit, which I am involved and is the purpose of this authorization.

I understand that this authorization will be valid from the date signed for a period of one year. A photocopy of this document shall be considered valid as if the original were offered. This authorization is only valid if submitted by Cefaratti Group, Inc.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided by the federal government's rules, which are in the United States Code of Federal Regulations at section 164.524.

_____ _____
Date signed Signature

Relationship to Patient: Self _____ Other_____

For internal use only:

HOLD FOR VIEW
dan_romaine@hotmail.com