AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION TO MY ATTORNEYS

GARBER LAW
A Professional Corporation
1200 Laurel Oak Road, Suite 104
Voorhees, New Jersey 08043
856 435-5800

Date: _____ Date of Accident: _____ Date of Service: _____

IDENTIFICATION AND AUTHORIZATION:
PROVIDER: _____ and any and all affiliates
NAME: _____
DATE OF BIRTH: _____ SSN: _____
ADDRESS: _____

I give my consent to disclose information from my confidential scholastic, employment, insurance, medical, psychological, alcohol and/or drug abuse records to **GARBER LAW, PC**

SPECIAL PURPOSE:

This authorization is given for the purpose of copying for verification, review and evaluation by **GARBER LAW, PC** or any representative thereof, with respect to pending or future civil litigation for personal injury and/or municipal court and/or criminal defense.

SPECIFIC RECORDS REQUESTED:

Any and all information or opinions regarding scholastic records, binding of coverage, cancellation notices, proofs of mailing, underwriting information and the physical condition and treatment rendered therefore, medical records, medical billing or loss of earnings rendered to the above-named individual.

REDISCLOSURE:

I acknowledge the potential for information disclosed pursuant to this authorization is subject to redisclosure by the recipient and will no longer be protected under HIPAA privacy rules.

STATEMENT OF OBLIGATION AND REVOCATION:

I understand that my authorization shall remain valid from the date of my signature. I have been information that I may revoke this authorization except to the extent that action has been taken in reliance thereon, by written or oral communication. I have also been information of my right, subject to Section 70.111.3 or the Mental Health Procedures Act, 1976, to inspect the information to be released and that all information will be handled confidentially, in compliance with the Health Insurance Portability and Accountability Act of 1996, Federal Privacy (P.L. 93-575), the Federal Alcohol and Drug Abuse Act (P.L. 93-255) and the Pennsylvania Drug and Alcohol Abuse Control Act (P.L. 221, No. 63).

SIGNATURE OF PERSON and WITNESS:

SIGNATURE _____ DATE: _____

WITNESS: _____ DATE: _____

RELEASE OF HIV INFORMATION:

I specifically request that information related to my HIV status be withheld from the above authorized release by signing this document here for a second time. A general authorization for release of medical or other information is not sufficient for this purpose by the Confidentiality of HIV-Related Information Act (Act 45 P>S> & 7601 et seq.)

SIGNATURE TO WITHOLD HIV INFORMATION: _____

STATEMENT OF EXPIRATION:

THIS CONSENT GIVEN ON THIS PAGE SHALL EXPIRE UPON THE CONCLUSION OF MY CASE.