AUTHORIZATION AND RELEASE OF MEDICAL INFORMATION

To: **All Health Care Providers**, including all Doctors, Dentists, Chiropractors, Hospitals, Laboratories, Pharmacies, and the Custodians of Records and Accounting Departments for any of these facilities:

To: All Employers and/or Custodians of Records and Accounting Departments for any entity in possession of confidential information:

Please be advised that my attorney **PAUL E. NUNU** and any member, associate or designee of his firm is authorized to obtain, inspect and copy or to be furnished, and to re-disclose as he may deem appropriate, any and all medical information or documentation, and or confidential information including but not limited to:

All medical records and bills, including specifically but not limited to all diagnostic imaging studies (including, but not limited to, Imaging reports, radiographs, CAT scans, PET scans, bone scans, MRI films, sonogram videotapes, nuclear imaging and angiograms), all therapeutic imaging studies (including, but not limited to, nuclear medicine or radiation therapy films), photographs, pathology materials (including, but not limited to, slide preparations and tissue blocks), laboratory reports, physicians' records, surgeons' records, discharge summaries, progress notes, consultations, prescriptions, records of drug abuse and alcohol abuse, physicals and histories, nurses' notes, patient intake forms, correspondence, psychiatric records, psychological records, social workers' records, insurance records, consent for treatment, statements of account, bills, invoices, or any other papers concerning any treatment (including conventional and alternative), examination, periods of hospitalization, confinement, diagnosis or other information pertaining to or concerning my physical or mental condition.

This disclosure is made at the request of the below named individual.

THE FOLLOWING APPLIES TO DRUG AND/OR ALCOHOL ABUSE/TREATMENT INFORMATION RECORDS – Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR 2) prohibit further disclosure of these records without the specific written consent of the person to whom they pertain, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. This authorization, however, is to be accepted as my express authority to disclose all such records to the law firm noted above, in accordance with the referenced statutory provisions.

THE FOLLOWING APPLIES TO HUMAN IMMUNODEFICIENCY VIRUS TESTING – Prohibition on re-disclosure: This information has been disclosed from records whose confidentiality is protected by state law. State law prohibits further disclosure of such information without the specific written consent of the person to whom they pertain, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. This authorization, however, is to be accepted as the express authority to disclose all such records to the law firm noted above, in accordance with the referenced statutory provisions.

This authorization is continuing in nature and is to be supplemented as to all information learned or determined after the date of the signature below. The authorization shall expire two years from the date of the signature below. This consent is subject to revocation in writing at any time, except to the extent that action has been taken in reliance thereon or that the authorization was obtained as a condition of obtaining insurance coverage. With respect to psychiatric information, refusal to grant consent to the release of information will not jeopardize patient's right to obtain present or future treatment except where disclosure is necessary for such treatment. **A photocopy of this Authorization shall be considered as effective and valid as the original.**

_____ _____

Signature of patient or personal representative | If signed by Parent or legal representative, state authority

_____ _____

Printed name of patient | Date

_____ _____ _____

Date of birth of patient | Social Security number of patient | Former/alias/maiden name of patient