AUTHORIZATION FOR ALLOWANCE OF USE, DISCLOSURE AND RE-DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____**,** of_____, Date of Birth: _____, do hereby authorize and direct the Health Care Provider to whom this document is provided to do the following:

1.) I hereby authorize _____**,** of _____ to use, allow access to and disclose the following protected health information from any and all records and/or bills held by said health care provider relating to me (or my child or ward), as directed below. In executing this document, I understand that the information used or disclosed pursuant to the Authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2.) Information shall be disclosed to the Law Offices of Alexander M. Nesson, The Crocker Building, 4 Court Street, Suite 105, Taunton, Massachusetts 02780 (508) 828-6540, Facsimile No: (508) 828-1288.

3.) The records and/or bills to be disclosed include all records and/or bills relating to treatment from _____ to the present, including, without limitation, any treatment or hospitalization for:

drug dependency	addiction
abuse	drug treatment
alcoholism	alcohol abuse
psychological or psychiatric conditions	mental health counseling
sexually transmitted diseases	sexual assault
domestic violence	acquired immunodeficiency syndrome (AIDS)

or tests for or infection with human immunodeficiency virus (HIV).

All of the foregoing may be produced unless specifically crossed out and initialed by me.

4.) The above information is disclosed for the purpose of: **Legal.**

5.) I further direct that, upon request, certified copies of any such information be provided.

6.) I further understand that:

a.) This Authorization may be canceled at any time by me in writing to the health care provider unless the information has already been released and, in any event, this Authorization will end on eighteen (18) months from the date set forth below.

b.) I understand that I may see the information being released as it is described above and, may obtain a copy of the protected health information maintained by said Health Care Provider.

c.) I understand that this request will not interfere with my eligibility for benefits, enrollment, treatment or payment of claims.

7.) If this release is signed by someone other than the patient himself/herself, then said individual represents, by virtue of said signature hereto, that he/she has the authority to act on behalf of the patient.

Dated: _____ _____

Signature of Patient/Legal Representative