AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient: _____

Address: _____

DOB: _____ SSN: _____

RELEASE OF INFORMATION:

1. The following person or entity is authorized to disclose my medical records:
   Name: _____
   Address: _____

2. This disclosure is to be made to the following person or entity:

   Watkins Law Firm, LLC
   3540 Independence Drive
   Birmingham, AL 35209

3. This disclosure is for the purpose of litigation and is at the request of the above-named patient.

4. Dates for medical records to be disclosed: _____

5. This authorization applies to the following information:

   _____ ***ALL*** information, including diagnosis, treatment, hospitalization, discharge, treatment/needs, and/or outpatient care for my condition, including psychological or psychiatric impairment, drug and/or alcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS) or tests for or infection with Human Immunodeficiency Virus (HIV).

   _____ ***ALL*** medical records and bills. _____ ***ALL*** records, notes, log sheets and bills.

   _____ ***ALL*** prescription records, invoices and bills. _____ ***ALL*** medical bills

   _____ ***ONLY*** the following records or types of information:

   _____

   _____

6. This authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This authorization only applies to treatment occurring before the date of signature.

7. I may be charged reasonable copy fees as indicated under state law for my request.

YOUR RIGHTS:

I may decline to sign this Authorization. I understand I may revoke this authorization at any time in writing. If I revoke this authorization, the medical provider will not take any action on it, except to the extent that action has already been taken.

By signing below, I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure.

Treatment or payment will not be based on my signing this authorization.

I understand that I may see and copy the information described on this form if I ask for it, and I may receive a copy of this form after I sign it.

I hereby have the authority to and voluntarily grant permission for the information to be released as described above.

_____

Patient/Parent/Legal Guardian Printed Name Dated: _____