HIPPA COMPLIANT HEALTH INFORMATION RELEASE AUTHORIZATION

In accordance with Virginia Code Sections 8.01-413 and 32.1-127:03

IDENTITY OF PATIENT: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

AUTHORIZED MEDICAL PROVIDERS: _____

DATE OF AUTHORIZATION: _____

DATES OF SERVICE: _____

NAME OF REQUESTOR: Virginia Beach Law Group
780 Lynnhaven Parkway, Suite 220
Virginia Beach, Virginia 23452

Dear Medical Provider:

1. SCOPE OF AUTHORIZATION: You are hereby authorized to furnish and release to Virginia Beach Law Group, or any of its employees and representatives, all of my Personal Health Information in your possession, control or custody that is requested by them, including but not limited to: any and all mental health records, office notes, history, physical, consultation notes, discharge summaries, order and progress notes, laboratory results, nurses notes, emergency room records, operative records, in-patient records and films of x-rays, MRIs or CT scans, pharmacy and drug records, medical bills and health insurance Medicaid or Medicare records, concerning any medical treatment that I received from you, at your institution, as well as all such records which you keep in the regular course of business are found in my medical records file. I hereby authorize release of all records regarding mental health, psychiatric (other than psychotherapy notes which must be requested by separate authorization), chemical dependency or HIV.

2. PURPOSE/REDISCLOSURE: The purpose of this disclosure is to allow my attorneys at Virginia Beach Law Group and their paralegals, to obtain fully prosecute and protect my interests in the personal injury case I may have that arises out of the incident occurring on the above date of loss. Therefore, the disclosed Personal Health Information may be re-disclosed by them as they, in the exercise of their sole discretion, see fit. I understand that this further disclosure by them may act as a forfeiture of my right to privacy concerning this information.

3. COPY AS VALID AS ORIGINAL: I ask that you accept a copy of this Personal Health Information Release Authorization as having the same validity, force and effect as an original.

4. EXPIRATION: This authorization shall remain in effect until five years from the above-referenced Date of Authorization. Upon the expiration of those five years, this Authorization shall terminate.

5. REVOCATION/EXPIRATION: I understand that I may revoke or limit the scope of this authorization by notifying the attorneys at Virginia Beach Law Group at their offices in writing of my desire to so revoke or limit. Furthermore, I do so revoke all authorizations given by me prior to the above-referenced Date of Authorization that may be received by you from any person or entity other than my attorneys at the Virginia Beach Law Group.

_____ _____
[ ] Patient Date
[ ] Patient's Legal Guardian (Relationship _____)
[ ] Patient's Representative (See Attached Power of Attorney)