

Angela V. Lallemond, J.D.

MN Rule 114 Qualified Neutral

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**HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION
PURSUANT TO 45 CFR 164.508**

TO: _____
Name of Healthcare Provider/Physician/Facility

Street Address

City, State and Zip Code

Telephone/Fax/Email

RE: Patient Name: _____ DOB: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

_____ Direct consultation with provider (verbal and/or written).

_____ All medical records (including those pertaining to mental or behavioral health services), meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

_____ All physical, occupational and rehab requests, consultations and progress notes.

_____ All laboratory reports or results regarding blood, urine or breath testing for alcohol or drugs.

____ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

This authorization specifically includes records prepared prior to the date of this authorization and records prepared after the date of this authorization during the pendency of this proceeding.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), alcohol or drug abuse, and mental health. I authorize the release or disclosure of this type of information.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records/information to:

Angela V. Lallemon
174 Main Street, Winona, Minnesota 55987
507-312-7975 (voice)
507-312-7979 (fax)

The protected health information requested under this Authorization for Release of Patient Information shall be released to Ms. Lallemon for the following purpose:

- ____ Custody Evaluation
- ____ Mediation
- ____ Early Neutral Evaluation (SENE)

I understand the following:

See CFR § 164.508(c)(2)(i-iii)

- a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- b. The information released in response to this authorization may be re-disclosed to other parties.
- c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein and shall be as valid as the original. This authorization shall be in force and effect until one year from date of execution at which time this authorization expires.

Signature of Patient or Legally Authorized Representative
[See 45CFR § 164.508(c)(1)(vi)]

Date