



HIPAA AUTHORIZATION FORM

1. _____ is authorized to make the requested use or disclosure.

2. The Shahid Law Office, L.L.C., 89 Broad Street, Charleston, South Carolina 29401, and representatives of this office may receive protected information about me for the purpose of possible litigation.

3. The specific information that should be disclosed is listed in the attached cover letter and may include any and all information which may be required regarding any medical condition and treatment rendered, including, but not limited to, emergency room reports, discharge summaries, operative reports, doctor's orders, nurses notes, medication records, x-rays, as well as any laboratory reports, including reference to psychiatric care, sexual assault, alcohol or drug abuse, results of test for infectious diseases, including AIDS/HIV, and if necessary, to allow them or any physician appointed by them, to examine any x-ray pictures taken or record regarding my medical condition or treatment. I also authorize that you provide them a full and complete copy of any bills that reflect the cost of such treatment.

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying the above facility listed in number 1 in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed on information previously requested and sent. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

6. This authorization expires on _____, 200____. A photo-static copy of this authorization shall be effective and valid as the original.

Witness

Signature

Date of Birth

Social Security Number