EQUI COPY
SERVICE | TECHNOLOGY | SOLUTIONS

Individual: _____AKA: _____

SSN: _____Date of Birth: _____

Disclosing Entity/Facility:
_____
_____
_____

Please be advised that our office legally represents the noted individual above and hereby designates EquiCopy as our agent to pursue, copy and produce any and all information described in this authorization pursuant to the California Code of Civil Procedures, section 1158.

Description of Information: This release applies to all medical records, documents, reports, X-Rays or other films, photographs, billings, studies, prescriptions or correspondence relating to the treatment, examination, or hospitalization, including but not limited to all physical or psychiatric conditions.

Patients Declaration: I specifically authorize the additional use and/or disclosure of the type of highly confidential information indicated next to my initials if any such information is contained in said records and therefore may be used or disclosed pursuant to this Authorization:

Patients Initials Required for Release:
__ Drug or Alcohol Abuse
__ Mental Illness
__ Psychotherapy Notes
__ HIV/AIDS/HTLV3 Testing, Diagnosis, Results, Treatment
__ Substance Abuse, Prevention or Treatment
__ Other: _____

I also give my approval for any and all employment, payroll, educational, job training, or any other type records as may be deemed necessary by my legal representatives.

As well, I approve the release of all police reports/records, arrest records, jail/prison records, and probation reports/records.

This authorization applies to all records both prior to, and after the date of my signature. It is understood that nothing shall be removed, deleted, altered or withheld from my records.

Purpose: At the request of the individual, the information sought is for the specific use of said person or law firm in representing the individual authorizing this release for claim relating to their injuries, benefits of other related legal matters.

This document covers information or material whose disclosure would otherwise be prohibited by state or federal statutes or regulation including but not limited to all HIPAA rules and regulations.

Expiration Date: This authorization is in force for 3 years from the date of signature herein due to the nature, duration, and extent of this case.

Right to Revoke: The individual has the right to revoke this Authorization at any time during which this Authorization is in force by giving written notice of revocation to EquiCopy. The person signing this authorization has received a copy hereof, and a photostat or facsimile of this authorization shall be considered as valid as the original.

No Conditions: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Re-Disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SIGNATURE: _____DATE: _____