AUTHORIZATION TO COPY MEDICAL RECORDS

Individual:_____ aka:_____
Social Security Number:_____ Date of birth:_____
Provider:_____
Requested by: Individual through attorney
Make disclosure to: Representative of Platinum Copy Services.
Information to be disclosed: Provider is directed to make available for copying all records pertaining to the Individual including but not limited to treatment, hospitalizations, evaluations, testing, and surgeries. This includes all files or records for all injuries or conditions in Provider's possession or under Provider's control that is held for any purpose. Nothing shall be removed, deleted, altered or withheld.

Additional information to be disclosed by Provider if the box is checked:

- ☐ All billing records showing all charges, expenses, costs and payments.
- ☐ Original X-ray films.
- ☐ Drug and alcohol abuse testing, evaluation and treatment.
- ☐ Mental health information consisting of but not limited to all notes, records and reports of psychotherapy diagnosis, evaluation and treatment.

No information is to be released regarding human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS).

Purpose of the requested disclosure: At the request of the Individual this information will be used for the purpose of aiding the Individual and his or her attorney in establishing the liability, nature and extent of a claim for injuries and disabilities and to establish benefits, expenses, compensation and damages. The information provided may be disclosed by the Attorney or Platinum Copy Service. to experts and other parties for evaluation or treatment for the purpose of prosecuting or defending any claim for which the Attorney has been engaged to pursue or defend.

Expiration date: This Authorization shall expire three years from the date of execution below.

Limitations on disclosure by provider: This Authorization does not permit Provider to allow the copying of the records by any other copy service or business associate as defined by the Health Insurance Portability and Accountability Act (HIPAA). This Authorization does not permit disclosure of any information to any person, entity, provider or insurance company other than the copying of the records by a representative of Platinum Copy Service. Any and all Authorizations signed before this Authorization are revoked.

Right to Revoke: The Individual has the right to revoke this Authorization at any time by giving the Provider written notice of revocation of this Authorization. The Individual has the right to refuse to sign this Authorization. The Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether the Individual signs the Authorization. Attorney designates and authorizes Platinum Copy Service As his or her representative to pursue any and all legal remedies necessary to compel the production of records from the Provider. A copy of this signed Authorization will be given to the Individual after it has been signed. A copy of this Authorization is as valid as the original. The original is not required to be shown.

Date: _____ _____
Individual's signature

Date: _____ _____
Form HIPAA 101 cc 56.11 Attorney's signature Control Number: