AUTHORIZATION

Pursuant to HIPAA, 45 CFR 164.508

Patient's Name: Date of Birth:

Social Security No.:

Information is to be released to: **The Higgins Kane Law Group, P.C.**
69 Delaware Avenue; Suite 100; Buffalo, New York 14202

Purpose of Disclosure: Litigation

Name of Facility/Person Authorized to Disclose Information:

Information to be released:

This authorization shall be valid for a period of one year from the date of signing.
I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken due to reliance upon it. Revocation of this consent must be made in writing addressed to the requestor above.

I understand that the information used or disclosed pursuant to this authorization has the potential to be re-disclosed by the recipient and such re-disclosure would not be protected by federal law.

A photocopy of this authorization is to be considered as valid as the original.

This authorization shall be valid for any records created prior to date of signing and records created within one year after date of signature.

Signature: ____

Print Name: ______________________________ Date: ____________

Relationship to patient: Self
(For minors: next of kin; if legally incompetent: legal guardian; if deceased: administrator/executor)

AUTHORIZATION
Pursuant to HIPAA, 45 CFR 164.508

Patient's Name: Date of Birth:

Social Security No.:

Information is to be released to:

Purpose of Disclosure: Litigation

Name of Facility/Person Authorized to Disclose Information:

Information to be released:

This authorization shall be valid for a period of 90 days from the date of signing.

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken due to reliance upon it. Revocation of this consent must be made in writing addressed to the requestor above.

I understand that the information used or disclosed pursuant to this authorization has the potential to be re-disclosed by the recipient and such re-disclosure would not be protected by federal law.

A photocopy of this authorization is to be considered as valid as the original.

This authorization shall be valid for any records created prior to date of signing and records created within 90 days after date of signature.

Signature: ______________________________

Print Name: ______________________________ Date: ______________

Relationship to patient: Self
(For minors: next of kin; if legally incompetent: legal guardian; if deceased: administrator/executor)