AUTHORIZATION FOR DISCLOSURE
RELEASE OF HEALTH INFORMATION/MEDICAL RECORDS

Health Insurance Portability and Accountability Act of 1996
45 CFR Subtitle A, Subchapter C, Part 164.512 (e) (1) (iii)

Identification of patient:

_____ _____
PATIENT'S NAME PATIENT'S SOCIAL SECURITY NO.

_____ _____
PATIENT'S DATE OF BIRTH FACILITY/PROVIDER TO RELEASE

Dates of service/treatment to be released: _____ **to** _____

Class of persons authorized to make the disclosure: All physicians and other health care providers who have examined, treated, consulted with, or x-rayed _____ and all hospitals, nursing facilities, rehabilitation facilities, clinics or laboratories in which _____ has been a patient and/or resident.

Description of information to be disclosed: You are hereby authorized and directed by the undersigned to give to the bearer of this authorization, or any photostatic copy thereof, any and all information relative to _____'s physical, emotional, and mental condition and permit the bearer to examine x-rays, laboratory reports, and medical records of any kind which reflect diagnosis, treatment, prognosis, and any other information concerning illness, injuries, or disability. Such information shall specifically include, but is not limited to, itemized billing records/statements, history & physical, operative reports, lab/pathology reports, consultation reports, physicians' orders, discharge/death summary, x-ray reports/images, other radiographic reports/images, emergency room records, face sheets, nurses' notes, flow sheets, pharmacy and medication records, care plans, assessment tools, screening tools, summaries, social workers, legal, and monitor strips, readouts or printouts. I understand that the specified information to be released may include, but is not limited to: history, diagnosis and/or treatment of drug or alcohol abuse, mental illness, psychological and/or psychiatric treatment, counseling records/notes, genetic testing or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). You are hereby authorized and directed to make available all such information for inspection and copying.

Person or entity to whom information is to be released/disclosed:

or it's agent

Republic Services, Inc.
4202 Sherwood
Houston, TX 77092

Purpose of this authorization: At the request of the undersigned individual and for insurance purposes.

Duration of this authorization: This authorization expires one (1) year from the date signed.

Right to Revoke: I understand that I may revoke this authorization in writing at any time by contacting the Release of Information Dept. at _____, except to the extent that action has been taken in reliance upon the authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected.

I understand that I have a right to a copy of this authorization.

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.

A photostatic copy of this authorization shall be considered as valid as the original.

_____
DATE SIGNED

_____
PRINTED NAME OF PERSON LEGALLY AUTHORIZED TO MAKE RELEASE

_____
SIGNATURE OF PERSON LEGALLY AUTHORIZED TO MAKE RELEASE

_____
CAPACITY OF PERSON LEGALLY AUTHORIZED TO MAKE RELEASE
(if self state “self”)