AUTHORIZATION FOR RELEASE OF INFORMATION

I, The Undersigned, Authorize:

Name of Facility: _____

Address: _____

City, State, Zip: _____

To release information from the records of:

Patient Name: _____

Patient Date of Birth: _____

Patient Social Security Number: _____

Information authorized to be released:

☐ Any and all medical records and films

☐ Any and all records from other providers

☐ Other: _____

Information to be released to: ***ATTORNEY'S NAME, ADDRESS***

Branford Manor Settlement ***on behalf of***
c/o JND Legal Administration
P.O. Box 91429
Seattle, WA 98111

Purpose for Disclosure: Product Liability Litigation

Understandings:

1. I understand that this consent may be revoked in writing at any time. With the exception and to the extent that disclosure of information has already occurred prior to the receipt of revocation by the above-named provider. If written revocation is not received, authorization will be considered valid for a period of time not to exceed three (3) years from the date of signing. To initiate revocation of this authorization, direct all correspondence to: _____.

2. I understand that this consent is to include disclosure of: **(PLEASE INITIAL EACH)**

☐ Alcohol and/or Drug Abuse Records

☐ Psychiatric Records

☐ Sexually Transmitted Disease Information

☐ HIV/AIDS Information

3. **I understand that a photocopy of this authorization is to be considered valid as the original.**

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

SIGNATURE: _____

Patient or Personal/Legal Representative **(Next-of-Kin or Legal Guardian to sign only if patient is a minor, legally incompetent or deceased)**.

PRINT NAME: _____ DATE: _____

Relationship to the patient of personal/legal representative signing: _____