Cefaratti Group
THE LITIGATION SUPPORT COMPANY

(Patient name)

(Hospital/Doctor name)

Patient Date of Birth: ***S.S.N.:***

I authorize you to release or disclose the following protected health information about the above-named patient: (include dates where appropriate)

☐ **ENTIRE MEDICAL RECORD:**

☐ **OTHER** (as specified):

I understand that the information to be disclosed may include records relating to alcohol or drug abuse, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex (ARC), sexually transmitted disease, billing records. It may also include information about behavioral or mental health services to the individuals or organizations listed below. I authorize you to release the information to:

CEFARATTI GROUP, INC., 4608 St. Clair Avenue, Cleveland, Ohio 44103

The purpose and need for such disclosure: FOR PRETRIAL DISCOVERY

I understand that I have the right to cancel this authorization, in writing, at any time by presenting my written cancellation to: Hospital/Doctor listed above. I understand that a cancellation will not apply to information that has already been released under this authorization. I also understand that information disclosed pursuant to this authorization may no longer be subject to state or federal privacy regulations and laws. I understand that information disclosed pursuant to this authorization may be re-disclosed to third parties and may no longer be protected by 45 USC 164.512 (HIPAA). Such parties are included, but not limited to other counsel in the lawsuit, which I am involved in, and which is the purpose of this authorization.

I understand that the covered entity may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization when the prohibition on conditioning of authorizations in 164.508 (b)(4)** applies.

> ****164.508(b)(4) *Prohibition on conditioning of authorizations.***
> **A covered entity may not condition the provision to an individual of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization**, except:
> **(i)** A covered health care provider may condition the provision of research-related treatment on provision of an authorization for the use or disclosure of protected health information for such research under this section;
> **(ii)** A health plan may condition enrollment in the health plan or eligibility for benefits on provision of an authorization requested by the health plan prior to an individual's enrollment in the health plan, if:
> **(A)** The authorization sought is for the health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations; and
> **(B)** The authorization is not for a use or disclosure of psychotherapy notes under paragraph (a)(2) of this section; and
> **(iii)** A covered entity may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.

I understand that this authorization will be valid from the date signed for a period of **one year**. A photocopy of this document shall be considered valid as if the original were offered. This authorization is only valid if submitted by Cefaratti Group, Inc..

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided by the federal government's rules, which are in the United States Code of Federal Regulations at section 164.524.

Date signed **Signature**

REVISED 1/2016