AUTHORIZATION FOR RELEASE OF HEALTH AND OTHER INFORMATION

1. Patient's Name: ______________________________ Date of Birth: __________ Social Security No.: ___________

2. I authorize any health plan, medical doctors, osteopaths, chiropractors, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or any other medical personnel or health care facilities or providers of any kind or nature (the "Releasing Parties") to release or disclose health information of the above named individual to **RECORDS ACQUISITION SERVICES, INC.** and/or its designated agents or representatives (706 Walnut Street, Suite 102; PO Box 908; Knoxville, TN 37901-0908) *so that* **RECORDS ACQUISITION SERVICES, INC.** may, in turn, disseminate copies of the same to all counselors who appear or intervene in the following legal action on behalf of one or more of the parties according the terms of its Express Warranty (RAS Alternative™):

   [Plaintiff(s)] v. [Defendant(s)]; [Court Type]; [Docket No.]

   A copy of all items procured pursuant to this authorization will be provided to the patient/plaintiff's counselor at no charge before or at the same time the items are made available to other requesting counselors of record and without any requirement that the patient/plaintiff's lawyer expressly request said items (the "Receiving Parties"). (*See* 45 CFR 164.508(c)(1)(ii))

3. This authorization is made in accordance with federal and state law and is valid for a period of twelve (12) months after being signed or at the conclusion of the legal action referenced in Paragraph 2 above, whichever occurs latest.

4. I understand that I, _________________________, may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization. A revocation is effective upon receipt by **RECORDS ACQUISITION SERVICES, INC.** of a written request to revoke and a copy of the executed authorization form to be revoked at the following address: 706 Walnut Street, Suite 102; PO Box 908; Knoxville, TN 37901-0908.

5. I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the Receiving Parties and may no longer be protected by federal and state law.

6. A description of the information pertaining to the individual identified in paragraph number 1 above that I authorize for use or disclosure includes the following:

   a) MEDICAL RECORDS - Any and all reports, records, notes, orders, consultations, correspondence, assessments, telephone message logs, pharmaceutical records, bills, radiographic reports, films and images, laboratory or pathology reports, or other medical records, including but not limited to protected health information as defined at 45 C.F.R. § 160.103, et seq. (a provision of the HIPAA Privacy Rule) of whatever kind or nature compiled and/or recorded by any health plan, medical doctors, osteopaths, chiropractors, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or any other medical personnel or health care facilities or providers of any kind or nature. "Medical records" does not include non-privileged written reports such as incident reports;

   b) MENTAL HEALTH RECORDS – Any and all mental health records from any and all psychiatrists, psychologists, social workers and any other mental health professional of any kind or nature, and including but not limited to such records as any and all medical records, psychotherapy notes, medical insurance records and any and all other documents pertaining to the mental health of the individual identified in paragraph number 1 above;

   c) EMPLOYMENT, INSURANCE AND EDUCATIONAL RECORDS – Any and all personnel records, attendance records, sick leave records, leave of absence records, disability records, workers compensation records, vacation records, evaluations, grievance file, insurance records, compensation records, school records, medical records and any and all other records kept or compiled, past or present, by any employer, insurer, school, university, trade school or local, state or federal governmental body or agency, pertaining to the health, employment and/or educational pursuits of the individual identified in paragraph number 1 above;

   d) SOCIAL SECURITY AND DEPARTMENT OF EMPLOYMENT SECURITY RECORDS – Any and all Social Security Administration and/or Tennessee Department of Employment Security records, including, but not limited to wage earning records, any records pertaining to a claim for, application for, provision of, or appeal by or on behalf of the individual identified in paragraph number 1 above for any benefits administered by the Social Security Administration or Tennessee Department of Employment Security (i.e., disability, survivor, Supplemental Security Income, unemployment, etc.);

e) <u>FEDERAL AND STATE TAX RECORDS</u> – Any and all Internal Revenue Service and/or Tennessee Department of Treasury records pertaining to the individual identified in paragraph number 1 above, including, but not limited to copies of 1040 series tax forms and all attachments (including W-2 forms, schedules, etc.) for the past (4) years filed by or on behalf of the individual identified in paragraph number 1 above.

7. This authorization for release of my otherwise private information is provided in connection with the legal action referenced in paragraph number 3 above in which allegations of wrongful conduct, damage or loss have been made making the above information discoverable under state law and authorizes the Receiving Parties to use and disclose this health information for all purposes associated with this legal action which includes review by experts, disclosure as part of official pleadings or court documents, review by one or more independent medical examiner(s), or as part of any other discovery or trial analysis process which may involve review by outside third parties.

8. I understand that my continued or future treatment by or payment to the Releasing Parties is not conditioned upon my providing or signing this authorization.

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

10. A photostatic copy of this consent is as valid as the original.

Acknowledged and agreed to on this the _______ day of _______________________, 20_____ by:

____
Signature of Patient or Personal Representative

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, complete the following and attach a copy of the supporting legal documents:

____
Personal Representative’s Name, if applicable

____
Relationship to Individual