**AUTHORIZATION TO RELEASE PROTECTED HEALTH CARE INFORMATION**

TO:

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR §164.508, the provider listed above is hereby authorized to release to GOSS & FENTRESS, PLC, 735 Newtown Road, Norfolk, VA 23502 (Tel. 757.466.1095) or any of its representatives, all medical records, including but not limited to: **office notes, history, physical, consultation notes, discharge summaries, order and progress notes, laboratory results, nurses notes, emergency room records, operative records, in-patient records and films of x-rays, MRIs or PET scans, Pharmacy and drug records, medical bills and health insurance Medicaid or Medicare records**, concerning any medical treatment that has received from you, at your institution, as well as all such records which you keep in the regular course of business that are found in your records pertaining to this patient.

A photostatic copy hereof shall be as valid as the original. I hereby authorize a free copy of my medical records pursuant to KRS 422.317 be sent, to the extent I have not already requested my one free copy.

The purpose of this authorization and request is to permit my attorney to obtain ALL medical information pertaining to the physical or mental condition of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. This authorization expires three (3) years from the date of the signature. The aforementioned expiration date has not passed, as this matter is ongoing.

I have the right to revoke this authorization in writing by providing a signed, written notice of revocation to the health care provider listed above and to GOSS & FENTRESS, PLC, 735 Newtown Road, Norfolk, VA 23502. Medical providers may not condition treatment or payment on whether the above-listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to re­disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*signature*)

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STATE OF KENTUCKY }

COUNTY OF FLOYD }

Subscribed and sworn to before me by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on this the \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_, 2015.

My Commission expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NOTARY PUBLIC, ID # \_\_\_\_\_\_\_\_\_\_

STATE AT LARGE, KY