Name of Health Care Provider: _____
Address: _____
_____

AUTHORIZATION AND DIRECTION FOR DISCLOSURE AND RELEASE OF MEDICAL RECORDS

I hereby authorize _____ hereafter referred to as the ("Health Care Provider") to release or disclose the health records of:

Name of Patient: _____
Date of Birth: _____
Social Security Number: _____

For the **PURPOSE** of: Litigation

AUTHORIZATION EXPIRATION DATE: ONE YEAR AFTER DATE OF MY SIGNATURE BELOW

YOU ARE HEREBY AUTHORIZED AND DIRECTED to disclose and release the following to the law firm of **Liskow & Lewis, One Shell Square, 701 Poydras Street, Suite 5000, New Orleans, LA 70139-5099; hereafter referred to as the "Recipient" of the health information.**

Any and all medical records including, but not limited to, physician's records; surgeons' records; discharge summaries; progress notes; consultations; pharmaceutical records; medication sheets; patient information sheets; consents for treatment; medical reports; x-rays and x-ray reports; CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films; interpretations of diagnostic tests; pathology materials, slides, tissues, and laboratory results and/or reports; consultations; physical therapy records; drug and/or alcohol abuse records; HIV/AIDS diagnosis and/or treatment; physicals and histories; correspondence; psychiatric records; psychological records; psychometric test results; social worker's records; other information pertaining to the physical and mental condition; all hospital summaries and hospital records including, but not limited to, admitting records; admitting histories and physicals; case records, discharge summaries; physician's orders, progress notes, and nurses' notes; medical record summaries; emergency room records; all other hospital documents and memoranda pertaining to any and all hospitalizations and/or out-patient visits; and all insurance records; statements of account, bills or billing records, or invoices; any other papers concerning any treatment, examination, periods or stays of hospitalization, confinement, or diagnosis.

For treatment dates: ALL

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the above referenced health care provider. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this protected health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by 45 CFR Parts 160 and 164.

Dated this _____ day of _____ 201__.

_____
Patient Signature

_____
Printed Name (write legibly)