BD&J
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HIPAA COMPLIANT AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH AND OTHER INFORMATION

EXPLANATION: This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. This form also authorizes the release of all employment, police and scholastic records pertaining to the claimant. This form allows the **Law Offices of Banafsheh, Danesh & Javid**, its agents, employees, investigators and attorneys to examine copy or Photostat, and to disclose to doctors, accountants, investigatory agencies, medical transcription agencies, insurance organizations and insurance support organizations, the health and other information described below. I understand that one potential consequence of my refusal to sign this authorization could be the denial of my claim based upon the lack of sufficient information to evaluate the claim. I understand that I am entitled to a copy of this authorization.

AUTHORIZATION:

I hereby authorize the following covered entity (Name and address of facility or individual):

_____

_____

to furnish to, and discuss with the **Law Offices of Banafsheh, Danesh & Javid**, its agents, representatives, employees, investigators and attorneys, health records, employment records or scholastic records pertaining to:

Name of patient/claimant: C/O Brittany Leigh Hochberg

Date of Accident/Occurrence: 12-9-24

SSN: Follow up

Date of Birth: 9-9-1992

This authorizes and requests the disclosure of all protected information including, but not limited to the following records and/or reports, within the following dates:

_____/____/_____ to _____/____/_____

- ☐ All **medical records** pertaining to examination, treatment ,consultation, billing, x-rays & associated reports, history, laboratory findings, admission & discharge reports, treatment records, diagnosis & prognosis records, nurses' & doctors' notes, all medical reports, photographs, video & audio recordings, digital or other images; autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records & specimens.
- ☐ All **billing records** including all ***itemized bills,*** statements, insurance claim forms, and records of billing to third party payers and payment or denial of

benefits.

- ☐ All **Disability, Medicaid, or Medicare** records including claims forms and record of denial of benefits.
- ☐ All **physical, occupational and rehab** requests, consultations and progress notes.
- ☐ All **employment**, personnel or wage records.
- ☐ All **pharmacy/prescription records** including NDC numbers and drug information handouts/monographs.
- ☐ All **radiology records & films/CDs** including CT scan, MRI,MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram & cardiac catheterization results, videos/CDs/DVDs/films/reels & reports.
- ☒ **Police Records,** traffic reports, criminal reports and any audio, video and pictures available at time of report.
- ☐ Other: (please specify)

_____

I understand that this may include information relating to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care, and/or treatment for alcohol and/or drug abuse.

USES: The requestor may use the medical records and type of information authorized only for the following purposes:
Insurance Claims, Legal Matters and Criminal Reports. Other (please specify):

_____

DURATION: I understand this authorization may be revoked in writing at any time, unless otherwise revoked in writing, this authorization will remain valid during the duration of this claim, or otherwise specified:_____

RESTRICTIONS: I hereby release the above covered entity from any/all legal liability that may arise from the release of this information to the party named above. I understand that the use and/or release of the above described information by the Law Offices of BD&J, is and will be restricted by and in compliance with applicable federal and state health care information and insurance privacy laws. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law, Privacy Rule, 45 C.F.R. § 164.508(c)(2).

A photocopy of this authorization shall be considered as valid as the original.

SIGNATURE _____
Print Name: C/O Brittany Leigh Hochberg Date: 12-16-2024

If signed by other than patient, such representative's authority to act for the patient is as follows:

LEGAL REPRESENATIVE TO PATIENT:
SIGNATURE: _____
Print Name: C/O Brittany Leigh Hochberg Date: 12-16-2024