AUTHORIZATION FOR DISCLOSURE OF:

☐ HEALTH INFORMATION
☐ POLICE INFORMATION
☐ EMPLOYMENT INFORMATION
☐ OTHER_____

Name: (Please Print)	**Date of Birth:**	**Social Security No.:**

SIGN HERE

(CHECK ONE): ☐ Patient ☐ Employee ☐ Party ☐ Individual

I, THE UNDERSIGNED, WHOSE NAME IS SET FORTH ABOVE, HEREBY AUTHORIZE THE USE, DISCLOSURE, REPRODUCTION, AND TRANSMITTAL OF MY INFORMATION AS DESCRIBED BELOW:

The following person or entity is authorized to make the Disclosure
This information may be disclosed to and used by:

GOODROW LAW OFFICE
LAW CHAMBERS BUILDING
345 Franklin Street, San Francisco, CA 94102
Tel: (415) 655-9478 for the purpose of:

☐ Performing legal or services related to my claim or defense,
☐ Other_____

The type and amount of information to be used or disclosed is as follows:

☐ ENTIRE RECORD FOR ALL DATES	☐ ENTIRE RECORD DATED FROM_____ TO_____
☐ ALL POLICE RECORDS, ARREST / INVESTIGATION REPORTS, STATEMENTS, LAB REPORTS, VEHICLE DATA RECORDER INFORMATION, WITNESS STATEMENTS	☐ DATA & RESULTS, EVIDENCE LOGS, 911 AUDIO, C.A.D. PRINTOUTS, CRIMINAL DATABASE QUERY RESULTS, DMV RECORDS, VISUAL IMAGES, P.A.S. READINGS, FIELD VIDEO
☐ TRAFFIC COLLISION REPORT, SUPPLEMENTAL REPORTS, ATTACHMENTS	☐ INVESTIGATION, FORENSIC, ACCIDENT RECONSTRUCTION, OR SURVEILLANCE
☐ DIAGNOSTIC / LABORATORY DATA AND RESULTS	☐ INSURANCE REPORTS AND UNDERWRITING FILES ☐ PARAMEDIC / AMBULANCE RECORDS
☐ IMAGING REPORTS, INCLUDING X-RAY, SONOGRAM & MRI	☐ CHART NOTES, REFERRALS, WORK RELEASES, DISABILITY DETERMINATIONS
☐ X-RAY FILMS	☐ SCHOOL / EDUCATION RECORDS
☐ PSYCHIATRIC AND OTHER MENTAL HEALTH RECORDS	☐ RECORDS OR INFORMATION RECEIVED FROM OTHER PROVIDERS
☐ BILLING AND PAYMENT RECORDS	☐ OTHER

I UNDERSTAND I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT TO REVOKE THIS AUTHORIZATION I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION IN THE MANNER AND PLACE DESIGNATED FOR DELIVERY OF SAID NOTICE BY THE DISCLOSING PERSON OR ENTITY. I UNDERSTAND THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. I UNDERSTAND THE REVOCATION WILL NOT BE EFFECTIVE UNTIL RECEIVED, AND WILL NOT APPLY TO INFORMATION WHICH IS OTHERWISE PERMITTED OR REQUIRED TO BE DISCLOSED BY LAW, OR AS FURTHER AUTHORIZED BY ME.

UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE UPON THE RESOLUTION OF MY CASE, OR IN TWO YEARS, WHICHEVER IS SOONER. I UNDERSTAND THAT THE INFORMATION IN MY RECORD MAY INCLUDE INFORMATION RELATING TO SEXUALLY TRANSMITTED DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY (HIV), AND THAT IT MAY ALSO INCLUDE INFORMATION ABOUT BEHAVIORAL OR MENTAL HEALTH SERVICES, AND TREATMENT FOR ALCOHOL AND DRUG ABUSE.

I UNDERSTAND THAT AUTHORIZING THE DISCLOSURE OF THIS INFORMATION IS VOLUNTARY. I CAN REFUSE TO SIGN THIS AUTHORIZATION. I NEED NOT SIGN THIS FORM IN ORDER TO ASSURE TREATMENT. I UNDERSTAND I MAY INSPECT OR COPY THE INFORMATION TO BE USED OR DISCLOSED, AS PROVIDED IN 45 C.F.R.164.524. I UNDERSTAND ANY DISCLOSURE OF INFORMATION CARRIES WITH IT THE POTENTIAL FOR AN UNAUTHORIZED RE-DISCLOSURE AND THE INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES. I UNDERSTAND THAT IF I HAVE QUESTIONS ABOUT DISCLOSURE OF MY HEALTH INFORMATION, I AM ENTITLED TO CONTACT THE DISCLOSING PARTY.

I AGREE THAT (1) THIS AUTHORIZATION OVERRIDES ANY PRIOR AGREEMENT TO RESTRICT INFORMATION PURSUANT TO *45 C.F.R. 164.502(b)(2)(II)*, (2) A COPY OF THIS AUTHORIZATION IS AS GOOD AS AN ORIGINAL, AND (3) I HAVE READ AND UNDERSTAND THIS AUTHORIZATION.

SIGNATURE	**DATE**
	SIGN HERE

NOTICE IS HEREBY GIVEN PURSUANT TO *45 C.P.R. 164.502(b)(2)(II)* [HIPAA PRIVACY RULE] THAT THIS AUTHORIZATION IS NOT SUBJECT TO THE HIPAA MINIMUM NECESSARY STANDARD.