

AUTHORIZATION TO FURNISH INFORMATION

This will authorize the disclosure of information, to include protected health information, about me, my minor child/ward/fiduciary or the person of whom I am the legal representative to the following person(s) or class of persons for purposes of legal representation:

Office of the Public Defender- Defender District 3A

RE: _____

Post Office Box 8047

Greenville, North Carolina 27834

from the following person(s) or class of persons or facility:

Service

Date(s): _____

The specific information that should be disclosed is:

Any and all medical records, reports, all tests and reports thereof, and statement of charges.

Any and all employment and work history record, memoranda or performance notes.

Any and all psychiatric or psychological records, reports, tests or evaluations.

Any and all investigations, reports, notes, reviews or data concerning the undersigned, whether held by government or private agencies, individuals, corporations or organizations.

Any and all educational records, including reports, tests, grades, and any and all information in academic files.

Entire medical history and all files in your possession.

Any and all Medicare and/or Medicaid claims and payment information concerning medical expenses incurred by me since the date of an incident or accident which is the subject of the firm's representation of me.

Other:

I understand that the information used or disclosed may be subject to re-disclosure by the Office of the Public Defender- Defender District 3A, and would then no longer be protected by federal privacy regulations. I may revoke

this authorization by notifying the above-listed person(s) or class of persons or facility of my desire to revoke it. However, I understand that any action taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization expires on _____, 200__, or upon completion of my representation by the Office of the Public Defender- Defender District 3A, whichever is earlier.

This the ____ day of _____, 200__.

Client/Parent/Guardian/Personal

Representative _____

Client's SSN _____

Client's DOB

Witnessed by:
