

AUTHORIZATION FOR RELEASE OF INFORMATION

I do hereby consent to and authorize _____ to disclose to the person(s) named, information from my medical records relating to my treatment. This release is to be limited to the specified reports within the specified dates of treatment I have indicated below. I understand that this consent shall operate as a complete release of liability to the healthcare provider and its employees for the release of information as specified below.

PATIENT NAME _____ DATE OF BIRTH _____

SSN _____

TREATMENT DATES _____

SPECIFIED REPORTS NEEDED (Check appropriate lines)

- Complete copy of my entire chart
- Abstract: face sheet, history & physical, discharge summary, all medical tests, operative section
- All Medical Tests: labs, EKG, X-Ray, operative section
- HIV/AIDS treatment records (if your information contains HIV/AIDS related information, you must check here)
- Drug/Alcohol treatment records
- Psychiatric treatment records
- Other _____

This information may be disclosed to and used by the following Recipient:

PATRICIA MARTIN STANFORD, ESQUIRE
PATRICIA MARTIN STANFORD, P.A.
8402 Papelon Way
Jacksonville, FL 32217
904-733-1732 fax 904-739-2347

for the purpose of investigating a claim for DES-related injuries and/or pursuit of DES product liability litigation.

Unless otherwise revoked by me, this authorization is valid for 6 months from the date below. Revocations MUST be made in writing. Revocation may not be made if action has already been taken in reliance on this Authorization.

I understand that once the above-named healthcare provider discloses my health information to the Recipient in accordance with the terms and conditions of this Authorization, it cannot guarantee that Recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use of my health information.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize the above-named healthcare provider and Recipient to use or disclose my health information in the manner described above.

Patient Signature