## AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

**TO:**

I hereby authorize the above named facility, any parent company, and any other any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf to release all medical information to **Allegro Record Solutions LLC, 7373 N. Lincoln Avenue, Suite 100, Lincolnwood, Illinois 60712,** for use in pending litigation.

This document authorizes the release of all medical information including Immunodeficiency disorders (HIV/AIDS), substance abuse and treatment, mental health/psychiatric treatment, radiology films, pathology materials, billing and insurance records, patient histories, prescription records, diagnosis, prognosis, admission notes, messages, correspondence, CDs, DVDs, floppy disks, photos and all other documents, electronic media and tangible items maintained by the facility as a designated record set pertaining to:

_____, _____- _____- _____, ____/___/_____
(NAME) (SSN) (DOB)

_____ _____
(ADDRESS) (PHONE)

The treatment dates to be released: (Check One) ☐ From ___/___/___ to ___/___/___
☐ All records retained by the facility

This authorization is continuing in nature and remains effective until the conclusion of litigation without the necessity for further authorization.

A copy of this authorization shall be considered as effective as the original.

I, the undersigned, have read the above and authorize the staff of the above named facility to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure and may no longer be protected. I hereby hold harmless the above named facility and any parent company from all liability and damages resulting from the lawful release of my Protected Health Information and understand that treatment, payment, enrollment or eligibility may not be conditioned on signing of this authorization.

_____ _____ _____
(DATE) (SIGNATURE OF PATIENT/PARENT/GUARDIAN) (RELATIONSHIP TO PATIENT)

*This authorization complies with 45 CFR 164.508.*