

# THE WRIGHT FIRM, P.A.

ATTORNEYS AT LAW

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NAME: \_\_\_\_\_  
SOCIAL SECURITY NO.: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
DATE OF INCIDENT: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
DATE OF TREATMENT: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

PLEASE FORWARD:

\_\_\_\_ 1. RECORDS, to include those circled below:

- |                               |                             |                      |
|-------------------------------|-----------------------------|----------------------|
| A. Admission summary          | H. Physician's orders       | N. Nurse's notes     |
| B. Emergency room records     | I. Physical examination     | O. History           |
| C. Physician's reports        | J. X-ray reports            | P. EEG, EMG, etc.    |
| D. Operative reports          | K. Progress Notes           | Q. Discharge summary |
| E. Office notes               | L. Complete records         | R. Lien information  |
| F. Billing ledger/information | M. All records after: _____ |                      |
| G. Other: _____               |                             |                      |

\_\_\_\_ 2. COPY OF BILL FOR SERVICES RENDERED.

\_\_\_\_ 3. CLEAN BILL FOR SERVICES RENDERED.

THANK YOU.

THE WRIGHT FIRM, P.A.

BY: \_\_\_\_\_

- General Authorization: I hereby authorize the recipient to furnish my attorney, The Wright Firm, P.A., the use or disclosure of protected health/financial/benefit information about me as described above and pursuant to Florida Statutes and federal regulations.
  - Specific Authorization: I authorize the release of medical, psychiatric, alcohol and/or drug abuse or any other information contained in any of my records. This disclosure is intended for use or disclosure by a physician, medical record department, billing department, diagnostic facility and/or medical facility ("medical provider") and/or provider of financial benefits.
  - HIV, AIDS, and/or Genetic Testing: HIV, AIDS and/or genetic counseling and/or testing information is confidentially protected by Federal and state laws which prohibits disclosure without specific written authorization of the undersigned.
  - Prior Authorization Cancelled: I hereby cancel any prior authorizations except group medical and/or automobile no-fault authorizations.
  - Expiration: This authorization will expire at the conclusion of this legal proceeding.
  - Purpose: The information may be used or disclosed for the purpose of legal proceedings. I understand that protected health information may also be used to carry out treatment, payment or health care operations.
  - Disclosure: I understand that if the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
  - Revocation: I understand that I may revoke this authorization by notifying the medical provider in writing. However, if I revoke this authorization, it will not have any affect on action taken by the medical provider in reliance on it before I revoke it.
  - Condition: I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing of this authorization.
  - Restriction: I understand that it is my right to request that the medical provider restrict how my protected health information is used or disclosed for purposes of treatment, payment or health care operations. The medical provider is not required to agree to any restriction I request; however, if the medical provider does agree to a restriction, the medical provider is bound to follow it.
  - Voluntary: I may refuse to sign this authorization and that it is strictly voluntary.
  - Photocopy: A photocopy hereof shall have the same force and effect as the original
- I have read the above and authorize the disclosure of the protected health information as stated.

DATE: \_\_\_\_\_

\_\_\_\_\_  
CLIENT'S SIGNATURE

Relationship to Patient:      Self      Natural Parent      Guardian      Personal Representative of Estate