The Cures Act

Authorization To Disclose Health Information

Name:
DOB:

I hereby authorize _____
to disclose specific health information from my records to my Attorney:

DAVID R. PALETTA
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for the specific purpose(s): **to support my application for Social Security disability benefits and/or Medicaid benefits.** Specific information to be disclosed includes **all correspondence, reports, diagnostic testing, evaluations, any and all other records relating to my physical and mental condition, diagnosis and treatment. I understand that this Authorization will expire one year from the date below.**

Time period of medical records. From _____ to _____ .

This Authorization and Release includes, but is not limited to any and all records from any educational institution I have attended, all vocational rehabilitation services, all services from federal, state or local agencies (i.e. DSS), and all services from non-profit organizations.

I understand that if I fail to specify an expiration date or condition, this Authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the Authorization is valid indefinitely. I also understand that I may revoke this Authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this Authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for the state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, hepatitis A, B, or C, alcohol abuse, drug abuse, psychological or psychiatric conditions, communicable diseases, or genetic testing, this disclosure will include that information. I also understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed Authorization.

_____ _____

Client **Date**