HIPAA Authorization for Release of Protected Health Information

Pursuant to 45 C.F.R. § 164.508 (HIPAA Privacy Rule)

IMPORTANT NOTICE TO PATIENTS AND AUTHORIZED REPRESENTATIVES

This form authorizes the disclosure of your protected health information (PHI) to Anchor Clinical Consulting, PLLC solely for the purpose of legal nurse consulting services. You have the right to revoke this authorization in writing at any time, except where disclosure has already occurred. Signing this form is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on your signature, except where permitted by law.

PART 1 — PATIENT / SUBJECT INFORMATION

Patient Full Legal Name	
Date of Birth	
Social Security Number (last 4 digits only)	
Current Address	
Phone Number	
Email Address (optional)	

PART 2 — PERSON AUTHORIZING THIS RELEASE

Complete this section if you are not the patient:

Full Name of Authorized Representative	
Relationship to Patient	
Phone Number	
Legal Authority (e.g., Power of Attorney, Guardian, Executor)	

PART 3 — PERSONS / ORGANIZATIONS AUTHORIZED TO DISCLOSE PHI

Name of Provider / Facility / Entity	
Address	
Phone / Fax	
Medical Record Number (if known)	
Provider Type (e.g., Hospital, Clinic, Pharmacy)	

PART 4 — INFORMATION TO BE DISCLOSED TO

Anchor Clinical Consulting, PLLC
Nicole Guzman, PMHNP-BC, MSN, Paramedic — Legal Nurse Consultant
Address: [Firm Address on File]
Phone: (972) 845-8445 · Fax: [On File] · Email: nicole@anchorclinicalconsulting.com
Purpose: Legal nurse consulting services in connection with civil / criminal litigation matter

PART 5 — DESCRIPTION OF INFORMATION TO BE DISCLOSED

Select all record types to be released:

- ☐ Complete Medical Records
- ☐ Inpatient Hospitalization Records
- ☐ Laboratory / Pathology Results
- ☐ Psychiatric / Mental Health Records
- ☐ Nursing Notes / Care Plans
- ☐ Billing / Insurance Records
- ☐ Emergency Room / Urgent Care Records
- ☐ Operative / Surgical Reports
- ☐ Radiology / Imaging Reports & Films
- ☐ Substance Use / Addiction Treatment Records
- ☐ Discharge Summaries
- ☐ Other: _____

Date range of records requested:

From Date _____ To Date _____

PART 6 — PURPOSE OF DISCLOSURE

- ☐ Legal Proceedings / Litigation Support
- ☐ Expert Witness Preparation
- ☐ Other: _____
- ☐ Case Evaluation
- ☐ At My Own Request

PART 7 — EXPIRATION OF AUTHORIZATION

Expiration Date (leave blank for one-year default) _____

Expiration Event (e.g., conclusion of litigation) _____

If no date or event is specified, this authorization expires one (1) year from the date of signature.

PART 8 — RIGHT TO REVOKE

You may revoke this authorization at any time by submitting a written notice to Anchor Clinical Consulting, PLLC and to the disclosing provider. Revocation is not effective to the extent that the authorized party has already acted in reliance on this authorization. Send revocation requests to: nicole@anchorclinicalconsulting.com.

PART 9 — RE-DISCLOSURE NOTICE

Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. Certain categories of records (mental health, substance use, HIV/AIDS) may carry additional protections under state and federal law that restrict re-disclosure.

PART 10 — FEES FOR COPIES

You may be charged a reasonable fee for the cost of copying and transmitting records. By signing this form, you authorize the disclosing party to charge such fees to the requesting attorney or law firm identified on the accompanying attorney intake form.

PART 11 — SIGNATURE

I have read and understand this authorization. I am signing voluntarily.

Signature of Patient or Authorized Representative _____ Date _____

Printed Name of Signer _____ Relationship to Patient (if not patient) _____

NOTARY ACKNOWLEDGMENT (if required by jurisdiction)

Subscribed and sworn before me this _____ day of _____, 20_____.

Notary Public: _____ Commission Expires: _____