AUTHORIZATION TO DISCLOSE PSYCHOLOGICAL RECORDS / PSYCHOTHERAPY NOTES PURSUANT TO 45 CFR 164.508(a)(2)

(To be signed only if Plaintiff is claiming psychological damages per Section 7 of the Plaintiff Fact Sheet)

1. **Entity(ies) authorized to use or disclose:**

   _____

   _____

2. **The individual (or the individual's personal representative) confirming the authorization:**

   Patient name: _____
   Address: _____
   Date of birth: _____
   Social Security Number (last four digits): _____

3. **Use or disclosure being authorized:** I authorize the disclosure of the following individually identifiable protected health information ("PHI") for Dates of Service from _____ to the present:

   a. My patient file related to all psychiatric, psychological or other confidential records relating to my emotional or other psychiatric/psychological condition(s), including substance abuse (including drug and alcohol information).

   b. All psychiatric/psychological records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, therapy notes, office and doctor's handwritten notes, records received by other physicians, and pharmacy or prescription records.

   c. My billing file, including any charges and payments for office visits, procedures, hospital visits, laboratory tests, x-rays, medication, and any other treatment for which charges were incurred.

4. **Entity(ies) authorized to receive and use:** I authorize the healthcare provider, medical facility, and/or their agents listed in Section 1 to disclose and discuss my PHI described in Section 3 to the following entity(ies):

   Faegre Drinker Biddle & Reath LLP, Attorneys, and/or Their Representatives
   320 South Canal Street, Suite 3300
   Chicago, IL 60606-5707
   Telephone: (312) 569-1000
   Facsimile: (312) 569-3000

5. **Extent of disclosure:** I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome

(AIDS), or human immunodeficiency virus (HIV). I realize that I have a right to review this information under supervision before it is released.

6. **Purpose:** This form is used to confirm the direction of an individual that the above healthcare provider use or disclose the individual's PHI for a particular purpose. The specific purpose for which this disclosure is authorized is legal.

7. **Expiration:** This authorization is being made at my request and shall remain effective for one (1) year from the date of execution of this authorization.

8. **Right to revoke:** I acknowledge that I have the right to revoke this authorization, in writing by sending written notification to Faegre Drinker Biddle & Reath LLP at the address listed above and to the healthcare provider disclosing the records. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

9. **Re-disclosure possible:** I understand that, if the persons or organizations I authorize above to receive and/or use the protected health information described below are not health plans, covered healthcare providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

10. **Duplications:** Any duplications of this authorization are acceptable by me and shall have the same effective and authority as originals.

11. **Conditional statement:** I understand that signing this authorization is voluntary and that my treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization for this disclosure.

12. **Signature:** I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the healthcare provider named above. I understand that, by signing this form, I am confirming my authorization that the healthcare provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

    Signature: _____ Date: _____

    If this authorization is signed by an individual's personal representative on behalf of the individual, complete the following:

    Personal Representative's Name: _____

    Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.