[Your firm name and logo]

AUTHORIZATION TO RELEASE HEALTH AND BILLING RECORDS TO COUNSEL
Client (patient): [Full name] | Date of birth: [MM/DD/YYYY] | Address: [ ]
Provider holding the records: [Provider name, records department address, phone or fax]
Law firm receiving the records: [Firm name], attention [Responsible attorney], [address], [phone], matter [reference]

Records to release
All of the following for dates of service from [start date] through the present: medical records, emergency and hospital records, operative and therapy notes, itemized billing statements, imaging reports, and pharmacy records. This release does not include psychotherapy notes.

Imaging (optional)
Please also provide the images themselves for [study and date] on disc or as an electronic file.

Specially protected records (optional)
I include only what I initial: [Initials] substance use disorder treatment [Initials] HIV test results [Initials] mental health records [Initials] genetic information. SUD counseling notes and psychotherapy notes are not included. Records of a federally assisted substance use disorder program need a separate consent that meets 42 CFR 2.31.

Purpose
The firm will use these records to evaluate and pursue my claim arising from [incident and date], and for no other purpose.

Duration
This authorization remains valid until [date] or the conclusion of this matter, whichever comes first.

Revocation
I may revoke this authorization by written notice to the provider at the address above, effective except for records it released in reliance on it before receiving my notice, and except where I signed it to obtain insurance coverage and other law gives the insurer the right to contest a claim under the policy or the policy itself.

Acknowledgments
My care, payment, plan enrollment and benefits eligibility are not conditioned on this signature. Records the firm receives could be redisclosed and might lose federal privacy protection. I have received a copy of this authorization.

Certification (optional)
Please include a signed records certification or affidavit of the custodian.

Client signature: _____ Date: [MM/DD/YYYY]
If signed by a representative: [Name], as [guardian / executor / administrator / attorney-in-fact], proof of authority attached
Firm use only: sent [date] | follow-up [date] | received [date] | pages [ ] | fee [ ]