Authorization to Release Records

By signing this form, I authorize you to release all writings/records including, but not limited to, confidential health information about me, psych records of any nature, employment/payroll records, or any other writing, by providing copies of my medical records, chart notes including but not limited to psychotherapy chat notes, mental health/psych records, HIV/AIDS records, alcohol/drug treatment reports of any nature, progress notes, x-rays reports, x-ray films, lab reports, pathology reports, treatment records, examinations, consultations, operative reports, plan of care, initial evaluations, any evaluations, hospitalization, any and all treatment of any nature for any condition, billing records, reimbursements, employment records, my personnel file, wage statements, paystubs, payroll records, law enforcement records, as well as any and all writings of any nature to Godfather Docs, LLC. Nothing shall be removed, altered, withheld or deleted.

Facility Name: _____

Additional Facilities: _____

_____

_____

Purpose: At the request of the individual, the information sought will be used for the purpose of aiding said person and/or law firm in establishing proper representation to individual authorizing the release to claim benefits for related injuries or for benefits of other related matters. The representing legal council has assigned ***Godfather Docs, LLC***. as the Discovery Agent for any and all types of information being requested in this Authorization to pursue proper litigation

Expiration Date: This Authorization is valid for 3 years from the date signed below.

Refusal to sign/right to revoke: I understand that this form is voluntary and that at any time I the patient can revoke this authorization by submitting a written notice of revocation in writing to ***Godfather Docs, LLC.*** The individual has the right to *not* sign this form, by refusing to sign this form it will not affect the ability to obtain treatment, payments, or eligibility for benefits.

Limitations: This authorization does not grant the authority to copy medical records to any other copy service or business as stated in the Health Insurance Portability and Accountability Act. ***Godfather Docs, LLC*** is a professional business that follows all the **"HIPAA"** rules and regulations and does not disclose any of the information to any third party.

Name: _____

AKA: _____

Signature: _____

Date: _____

Date of Birth: _____

SSN: _____