Matrix Document Imaging
The California Attorney Support Team
www.Legal-Records.com

AUTHORIZATION

Individual: _____ **AKA:** _____

SSN: _____ **Date of Birth:** _____

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this Authorization is voluntary. I also understand that the released information may be subject to re-disclosure by the recipients and no longer protected by federal privacy regulations pursuant to the Evidence Code, Code of Civil Procedures, Labor Code or any other State of California Code sections relative to the issues regarding the copying of my records.

Specific Description of Information: This release applies to all documents, records, reports, X-Rays or other films, photographs, billings, studies, prescriptions or correspondence relating to my treatment, examination, or hospitalization, including but not limited to all physical or psychiatric conditions. I give my approval for any and all employment, payroll, educational, and/or job training records as may be deemed necessary by my legal representatives. Additionally, I approve the release of any and all police reports/ records, arrest records, jail/prison records and probation reports/records. This Authorization applies to all records both prior to and after the date of signature. Nothing shall be removed, deleted, altered or withheld.

Disclosing Facility: _____

Purpose of Requested Disclosure: 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 ***Matrix Document Imaging, Inc.*** 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 a period of 3 years from the date signed below.

Right to Revoke: The Individual has the right to revoke this Authorization at any time by submitting a written ***Notice of Revocation*** to *Matrix Document Imaging, Inc.* The Individual also has the right to refuse to sign this Authorization, knowing that such refusal to sign, will not affect the Individual's ability to obtain treatment(s), payment(s), or eligibility for benefits. The person signing this Authorization has received a copy. A reproduced copy of this Authorization shall be as valid as the original.

Limitations On Disclosure by Provider: This Authorization does not permit provider to allow the copying of requested records by another copy service or business associate as stated in the *Health Insurance Portability and Accountability Act* **"HIPAA"**. This Authorization does not permit the disclosure of information to any person, entity, provider or insurance company other than the representative copying

records on behalf of *Matrix Document Imaging, Inc.* Any and all prior signed Authorizations will be revoked.

SIGNATURE: _____ **DATE:** _____