HIPAA Release Form - New Jersey

To: Nj Health Care Facilities

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

22 S Clinton Ave,

Street Address

Trenton, NJ 08609, United States

City, State, and Zip Code

RE: Patient Behavior: Acute Kidney Injury

Date of Birth: June 16, 1974 Social Security Number: 34-0002-3324

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- [x] All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient, and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.
- [x] All physical, occupational and rehab requests, consultations and progress notes.
- [x] All disability, Medicaid or Medicare records including claim forms of denial of benefits.
- [x] All employment, personnel or wage records.
- [x] All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.
- [x] All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- [x] All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third-party payers and payment or denial of benefits for the period June 16, 2023 to June 16, 2024.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes:

Drug test and HIV Testing

This authorization is given in compliance with the federal consent requirements for the release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

Jerome Burlington

Name of Representative

Attorney

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

2273 Kelley Road

Street Address

Gulfport, Mississippi(MS), 39501

City, State, and Zip Code

I understand the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

b. The information released in response to this authorization may be re-disclosed to other parties.

c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

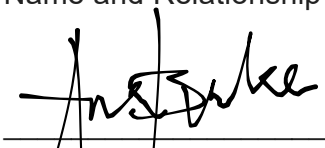
Signature of Patient or Legally Authorized Representative

June 16, 2023

Date

Ana Burke

Name and Relationship of Legally Authorized Representative to Patient



Witness Signature

June 16, 2023

Date