AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO the Provider: _____
_____
_____

You are hereby requested to permit any representative of the firm of _____ (hereafter the "Bearer") to inspect and make copies of all hospital and other confidential medical records that are in your possession concerning my physical or blood condition and mental health records **if checked**. This authorization allows only the production of documents. It does not authorize the Provider to otherwise communicate with the Bearer about the contents of the records or the condition of the undersigned.

Please provide the requested information for all dates of treatment and/or hospitalization with you. The information to be disclosed is:

- ☒ Admission reports
- ☒ History & Physical exams
- ☒ Laboratory tests & diagnostic reports or studies
- ☒ Discharge summaries
- ☒ Social history
- ☒ Nurses' Notes
- ☒ Progress reports
- ☒ Correspondence
- ☐ Death Certificate
- ☒ Outpatient records
- ☒ Consultation reports
- ☒ Pathology reports
- ☒ Nurses and doctors notes
- ☒ X-rays
- ☒ X-ray reports
- ☒ Billing statements and X-ray film
- ☒ Ambulance and emergency rescue reports
- ☐ HIV/AIDs status or records
- ☐ Other
- ☐ MMPI and Mental Health records

This information is to be supplied because I have commenced a civil action regarding an allegedly defective vehicle and the defendants seek these records as part of their defense. I understand that any re-disclosure of these records is protected by the Confidentiality Order entered in *In re Yamaha Motor Company Rhino Products Liability Litigation, MDL 2016.*.

Treatment, payment, enrollment or eligibility of benefits cannot be conditioned on obtaining the individual's authorization.

I understand that I may revoke this consent at any time in writing and that upon fulfillment of the above-stated purpose(s), this consent will automatically expire without my express revocation.

This authorization shall remain effective for **six months** from the date hereof. A photocopy of this authorization will be treated in the same manner as the original.

This authorization complies with the requirements of the Federal HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule, effective April 14, 2003.

Date: _____ _____
Signature:

_____
Patient's Name

Patient's Date of Birth: _____ _____
(Address)

_____
Patient's Social Security No._____ City State Zip