

**PATIENT AUTHORIZATION FOR THE  
RELEASE OF PROTECTED HEALTH INFORMATION (PHI)  
(HIPAA Compliant)**

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_, its agents, employees and associates, to release the protected health information (**physical and/or mental**) that is described below, to:

**JAY ROTHLEIN, ESQ. (his agents and employees)  
800 West Ave, Ste. C-1  
Miami Beach, Florida 33139**

The protected health information released herein (either physical and/or mental) is specifically as follows:

**any and all medical documentation, medical history, medical records, medical reports**

This protected health information is to be used for the following purpose:

**SOCIAL SECURITY DISABILITY CLAIM**

This release may be revoked by a signed and properly dated written revocation, delivered to the medical provider or its copy service, *provided* that this release cannot be revoked as to protected health information that had been previously released in reliance on this document.

I understand that a refusal to sign this form will not result in a denial of health care by the hospital or any other health care provider and that this release has not been coerced by a health care entity or any of its business associates.

I understand that once the PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, insurance companies and even may become public record if filed with a court of law.

This Medical Authorization shall expire upon final resolution of my pending claim/case as stated above.

Dated this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
(Print Name of Patient)

Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_