

**VALID AUTHORIZATION UNDER 45 CFR Sec. 164.508  
(HIPAA AUTHORIZATION)**

Pursuant to 45 CFR Sec. 164.502(a)(1)(iv) a covered entity is permitted to disclose protected health information pursuant to and in compliance with a valid authorization under Sec. 164.508.

I, \_\_\_\_\_, an individual, hereby authorize:

1. Any and all health care providers and/or other persons or entities who have possession of any protected health information relating to me,
2. to disclose any and all protected health information, including, but not limited to any and all designated record sets, medical records of every form or description, billing records of every form or description,
3. to: David L. McGuffey and his employees, at:

Law Office of David L McGuffey, LLC 202 W. Crawford Street, Suite B Dalton, GA 30720 (706) 428-0888
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4. The persons in paragraph 3 of this Release are authorized to request any and all protected health information covered by this Release, or may specify particular information. The purpose of this Release is at my request and for my convenience. The protected health information requested shall be timely delivered to the persons and to one of the addresses in paragraph 3 or by any other delivery method they request in writing.
5. I understand that I am not required to execute this release, that I may refuse to do so, and that no treatment or benefits eligibility is conditioned on its execution. I understand that I may revoke this release by delivering written notice to my Attorneys, but I agree I will not do so while they are representing me. This authorization shall terminate on the first to occur of: (1) my death or (2) upon my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. This revocation shall be effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity has taken action in reliance on it. By signing this Authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the person or persons whose name is written in paragraph 3 of this authorization and the information once disclosed will no longer be protected.

Signed this \_\_\_\_ day of \_\_\_\_\_, 2004.

\_\_\_\_\_  
**Patient**

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
NOTARY