James H. Sandman, P.C.
30 Green Street
Newburyport, MA 01950
(978) 465-9900 | Fax (978) 462-6470
INFO@JSANDMANLAW.COM

AUTHORIZATION TO USE OR DISCLOSE PROTECTED OR PRIVILEGED HEALTH INFORMATION

Please complete, sign and Fax, mail or hand-deliver this form to James H. Sandman, P. C

1. **I hereby authorize** (Name of Doctor or Facility)_____to use or disclose the following protected or privileged health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. **Patient Name:** _____ Date of Birth: _____

   Address:(Street, City, State, Zip)_____

3. **Information to be disclosed to:**
   Law Offices of James H. Sandman, P.C. , 79 State Street, Newburyport, MA 01950

4. **Disclose the following information for treatment dates:** _____ to _____

( ) Complete Medical Record	( ) Consult	( ) Physical Therapy
( ) Abstract	( ) Outpatient Records	( ) Emergency Reports
( ) Face Sheet	( ) X-ray	( ) Psychiatric Records
( ) Discharge Summary	( ) Laboratory	( ) Other Specified
( ) History & Physical	( ) Pathology _____	

5. **The above information is disclosed for the following purposes:**

   ( ) Medical Care ( ) Legal ( ) Insurance ( ) Personal ( ) Other

6. I understand I have the right to refuse to sign this authorization.

7. I understand I may revoke this authorization at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this authorization shall be as acceptable as the original.

8. This authorization expires on: _____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed name of Patient or patient's representative Relationship to patient or authority to act for patient