PUSCH & NGUYEN
INJURY LAWYERS

MEDICAL AND HOSPITAL AUTHORIZATION

DATE:_____

I, _____, authorize and request any physician or other person or any hospital or other institution by whom or in which I have received treatment for injuries to furnish my attorney, Jerry Pusch, and/or his designated representatives, full information relative to such treatment of me, or residence in any hospital or institution and to supply said representative with reports and history of my case as he may request, including but not limited to initial report of examination, office notes, final report of examination, surgical consent, discharge summary, consultation reports, emergency room records, operative reports and findings, diagnostic tests, entire office chart, graphic chart, history and physical, physicians' orders and notes, nurses' notes, reports of tests and x-rays abstract, prescription expenses, entire hospital records and medical bills.

I understand that the information in my health records may include test, results, and other information relating to Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS). It may also include information about mental/behavioral or Psychiatric services, and treatment for alcohol and substance usage.

I understand that I may refuse to sign this authorization and that it is strictly voluntary.

I understand that I may revoke or withdraw this authorization in writing at any time, except to the extent that action has been taken and if not earlier revoked.

I understand that the information disclosed pursuant to the authorization is subject to re-disclosure by the recipient and is no longer protected health information.

This does not authorize you or any other medical authority to prepare special reports, to respond to any verbal or written questions regarding my medical treatment or condition, or to discuss my healthcare with anyone else without my written approval or that of my attorneys at **Pusch & Nguyen Law Firm LLP.**

This authorization shall be effective for one hundred eighty (180) days from the above date.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

_____
Signature

_____
Social Security Number

_____
Date of Birth

_____
Address

_____
City, State, Zip

_____
Telephone Number