Authorization for Release of Medical Records and Protected Health Information
In Re: 3M Earplugs

I**, _____**, the undersigned, in compliance with regulatory requirements of HIPAA, hereby authorize and request **_____,** to release or disclose to bearer, or permit bearer to view, and/or to furnish bearer with copies of all medical and pharmacy records, tests, x-rays or other information regarding my treatment, drug prescriptions, billing records, hospitalizations, and/or outpatient care for _____. This authorization will be valid for one year from the date it was signed, unless revoked sooner, and includes records that are created after the date this authorization is signed, up until the expiration date.

I further authorize you to provide electronic access and/or photocopy and mail all documents, records, laboratory results, prescription records, or other medical information to my legal counsel:

LIEFF, CABRASER, HEIMANN & BERNSTEIN, LLP

250 Hudson Street
8th Floor
New York, NY
Telephone: (212) 355-9500
Facsimile: (212) 355-9592

I understand that I may revoke this authorization in writing at any time, unless my medical records have already been released as permitted by this form.

This **information will be used for legal investigation purposes**. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the rule.

I agree that a photocopy of this authorization be accepted with the same authority as the original. I agree that the above referenced individual may also communicate orally with regard to my medical records and/or medical condition, as HIPAA shall so provide.

I understand authorizing the disclosure of information identified in this authorization is voluntary, and this authorization is not intended to alter the patient's ability to receive medical care from any health care provider.

Non-medical records release authorization: This authorization shall also apply to personal records concerning and legally available to the person named herein, including all billing records, school records, all court records and all employment records.

Patient: _____

Date of Birth: _____

Date of this signature: _____

If not the patient, name of the person signing form: _____

Authority to sign on behalf of patient: _____

Signed: _____