# EMERGENCY MOBILE HEALTH CARE, LLC
## HEALTH INFORMATION MANAGEMENT
## *Authorization for Use and/or Disclosure of Protected Health Information*

I, the undersigned, hereby authorize Emergency Mobile Healthcare, LLC (the "EMHC") to use and/or disclose the information, oral or recorded in any form or medium created or received which relates to the past, present, or future physical or mental health or condition, or provision of healthcare, or for past, present, or future payment or the provision of healthcare, including but not limited to, any patient questionnaire, intake information, health insurance and provider information, history and physical, physician notes, consultation notes, physician orders, nurses notes, patient assessments, care plans, treatment records, prescription and medication records, diagnostic test reports, x-rays, tissue slides, lab reports, psychological reports, billing and payment records, and records and communications from other healthcare providers with respect to the care or treatment in connection with _____. (Patient Name and Date of Birth)

The attorneys and staff of the law firm(s) of _____ ("Law Firm"), the insurance personnel at _____ ("Insurance Company") [if none, write "none"], and their designated representatives ("Representatives"), including but not limited to consulting and testifying expert witnesses, are hereby authorized to make the requested use or disclosure or to speak privately to my healthcare professionals at EMHC, or to take testimony at deposition or trial as may be requested.

EMHC is hereby authorized to make the requested use or disclosure of the information set forth herein to the Law Firm, the Insurance Company, and their Representatives.

The purpose of the requested use or disclosure is at the request of the individual patient and is necessary to allow investigation and determination of the healthcare history and background including diagnosis and treatment that have been made at issue in the claim filed.

This Authorization expires upon the date of final resolution after all appeals of the above-mentioned claim or upon _____ (insert date or an event that triggers expiration), [if none, write "none"], whichever is later, as applicable.

I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing and must clearly state that I revoke my authorization for EMHC to use and/or disclose all of my protected health information, or, in the alternative, for any of my protected health information specifically described above. Valid revocation must be signed and dated and addressed to EMHC's Chief Executive Officer. I understand that my revocation is not effective to the extent EMHC used and/or disclosed my protected health information in reliance upon this Authorization prior to the date EMHC receives my revocation.

I understand that EMHC may not condition treatment, payment, enrollment or eligibility for benefits on executing this Authorization.

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations.

I acknowledge that the records obtained per this Authorization may be disseminated to agents and/or associates of counsel for EMHC as well as its consulting and testifying expert witnesses, and that any such information disseminated will no longer be protected by HIPAA privacy standards.

By signing below, I further acknowledge that a copy of this signed Authorization has been provided to me.

I hereby certify that I have received a copy of this Authorization Form.

_____ _____ _____
Signature Date Date of Birth

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

We, the subscribing witnesses hereto, are personally acquainted with and subscribed our names hereto at the request of the declarant, an adult, whom we believe to be of sound mind, competent and fully aware of the action taken herein and its possible consequence.

_____ _____
Witness Witness

On this ____ day of _____, 20___, the said _____ (the Patient or Patient's authorized representative), and _____ and _____ as Witnesses, each known to me (or proved to me on the basis of satisfactory evidence) to be the persons whose names are subscribed to this instrument in the capacities shown, personally appeared before me, a Notary Public within and for the state and county aforesaid, and acknowledged and certified that they freely and voluntarily executed this Authorization certifying that the Law Firm is representing the Patient as legal counsel in connection with the claims and authorizing EMHC to comply with the terms set forth in this Authorization for the purposes stated herein.

_____
Notary Public

My Commission Expires: _____