

DESCRIPTION OF ACCIDENT (be detailed)

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DATE AND TIME OF ACCIDENT	LOCATION OF ACCIDENT	POLICE REPORT MADE?
		YES/NO

HAVE YOU SEEN A DOCTOR	DOCTOR/HOSPITAL'S NAME AND PHONE	INJURIES SUFFERED
YES/NO (IF NO, REFER TO TEXAS HEALTHCARE (972) 392-3400)		

WITNESS INFORMATION	WITNESS INFORMATION
NAME: ADDRESS: PHONE: WHAT WAS WITNESSED:	NAME: ADDRESS: PHONE: WHAT WAS WITNESSED:
PICTURES TAKEN?	YES/NO (If yes, request copies)
Has client contacted any other attorneys?	YES/NO (If yes, who?)

NOTES:

HIPPA AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

TO:

Physician, Provider or Facility Name:					
STREET ADDRESS		STREET NAME		Ste. #	CITY
					STATE
					ZIP CODE

PATIENT:

Patient Name:	
Social Security Number:	
Date of Birth:	
Date(s) of Service:	

PERSON/ENTITY TO WHOM RECORDS SHALL BE RELEASED:

Name of Attorney:	Jeffrey J. Beltz or Rajish Jose
Firm:	The Beltz Law Firm
Street Address:	10103 Garland Road
City, State, Zip:	Dallas, TX 75218
Phone Number:	(214) 321-4105
Fax Number:	(214) 321-4157

I, _____, hereby authorize the release of information to Jeffrey J. Beltz or Rajish Jose and The Beltz Law Firm from the medical records pertaining to me. This release applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The information will be used or given out for the purposes of handling the attorney's or law firm's duties in the investigation and possible litigation of claims in which I am involved. This authorization is initiated at my request and the health information will be disclosed at my request. Information used or disclosed pursuant to this authorization may be subject to re-disclosure or shared by the persons or organizations receiving the information and no longer protected.

Jeffrey J. Beltz or Rajish Jose and The Beltz Law Firm are permitted to receive the information and are hereby appointed as my attorneys-in-fact/representatives for the limited purpose of obtaining and using any and all information the releasing persons or organization may have concerning treatment or services rendered to the undersigned for any reason, whether inpatient or outpatient, including but not limited to:

- Face sheet;**
- Intake, history, and physical;**
- Emergency room notes (handwritten and/or typed);**
- EKG, Holter monitor, Echo, and PFT;**
- Lab/pathology results and reports;**
- Results of summary testing;**
- Operative report;**
- Radiology records, X-rays, MRIs and related notes and reports;**

Consultation notes and reports;
Charts, progress notes, case notes, nurse's notes, and dictation;
Opinions, diagnoses, prognoses, and treatment plans;
Orders;
Statements and/or bills;
Dental records, notes, reports, summaries, and treatment plans;
Medication summary, pharmaceutical records including but not limited to date of prescription, prescribing physician, name of drug, dosage and amount dispensed;
AND
Any other medical information regarding any treatment, including documents to and from other health care providers, attorneys, insurance companies, etc.

Furthermore, _____ and it's agents and representatives are authorized to discuss my physical and mental condition with Jeffrey J. Beltz or Rajish Jose and The Beltz Law Firm and Jeffrey J. Beltz or Rajish Jose and The Beltz Law Firm's agents and representatives.

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that the specified information to be released may include: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. I understand that I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing Law.

Unless revoked sooner, this authorization expires one (1) year from the date of my signature below.

A photocopy or facsimile transmission of this authorization has the same force and effect as an original.

PATIENT'S SIGNATURE

DATE