

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED INFORMATION

Information to be Used or Disclosed

The information covered by this authorization includes:

- Medical history, physical condition, treatment, consultants, hospital, medical and office records, x-rays and reports, tests or other diagnostic procedures.
- Wage and employment records.
- Attendance and scholastic records.
- Previous lawsuits and/or claims handled by you on my behalf, including but not limited to, answers to interrogatories, supplements thereto, any and all discovery, medical reports and records, deposition transcripts, expert reports and hospital records.
- Other _____

I understand that the statement(s) used and disclosed under this Authorization form may include information relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

TO: _____
(Name and address of person/organization)

Persons to Whom Information May Be Disclosed

This use and disclosure is at the request of the individual signing below.

Information described above may be disclosed to my attorneys, **Law Offices of Lane M. Ferdinand, P.C., 505 Morris Avenue, Springfield, NJ, 07081**, or their representatives.

Expiration Date of Authorization

This authorization is effective through _____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Lane M. Ferdinand. You should contact the Title of Privacy/Compliance Officer to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Dated: _____
Signature _____
Print Name: _____
Social Security No.: _____
Date of Accident: _____

(Revised as of 4/14/03)