AUTHORIZATION TO RELEASE MEDICAL RECORDS

The undersigned, _____, hereby authorizes and directs _____to release, subject to the limitation or restrictions indicated below, all hospital and medical records including, without limitation, all hospital and medical bills and statements of accounts, all hospital charts, nurses notes, diagnostic studies, x-ray, CAT and MRI slides and reports, admitting and discharge summaries, and all other medical information whatsoever pertaining to the health care and treatment of _____ from _____ to present to her attorneys:

Bruning & Associates, P.C.
333 Commerce Drive, Suite 900
Crystal Lake, IL 60014

for their use in connection with her legal representation.

This Authorization is subject to the following limitations or restrictions, if any:

☐ No Limitations or Restrictions-**YOU ARE TO RELEASE MY ENTIRE MEDICAL RECORD** including Mental Health Notes.

☐ The following Limitations or Restrictions apply (Place a check on the line for each type of information you **DO NOT** wish to be released:

☐ **MENTAL HEALTH**

☐ **ALCOHOL/SUBSTANCE ABUSE** ☐ **X-RAY NOTES**

☐ **LABORATORY REPORTS** ☐ **OPERATIVE NOTES**

I understand that I can cancel this authorization in writing at any time. I further understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by my attorneys and that if such re-disclosure occurs that the information disclosed pursuant to this authorization may no longer be protected by the HIPPA privacy provisions. **A copy or facsimile of this authorization shall be operative as an original.** This authorization is valid for ninety (90) days from the date entered below.

Dated this ___ day of _____ 201__.

_____
Client:

_____
Witnessed by: