REPLICA
P.O. Box 40332
Downey, CA 90239
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AUTHORIZATION TO COPY MEDICAL RECORDS IN COMPLIANCE WITH HIPAA

Individual: _____ **AKA:** _____

SSN: _____ **DOB:** _____

Provider: _____ **Requested by:** Individual_____

Disclosing Facility: REPLICA_____

Information to be disclosed: This release applies to all documents, records, reports, X-rays, or other films, photographs, billings, studies, prescriptions or correspondence relating to my treatment, examination, or hospitalization, including but not limited to all physical or psychiatric conditions. Approval is also given for any and all employment, payroll, educational, and/or job training records as may be deemed necessary by my legal representatives. I also approve the release of any and all police reports/records, arrest records, jail/prison records and probation records. Nothing shall be removed, deleted, altered or withheld.

No information is to be released regarding human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS).

Purpose of Requested Disclosure: At the request of the Individual this information will be used for the purpose of aiding the Individual and his or her attorney in establishing the liability, nature and extent of a claim for injuries and disabilities to establish benefits, expenses, compensation and other damages. The Attorney of record has assigned **REPLICA** as the Discovery Agent for any and all types of information being requested for the purpose of prosecuting or defending any claim for which the Attorney of record has been engaged to pursue or defend.

Expiration date: This Authorization is valid for a period of 3 years from the date of signature.

Limitations on disclosure by provider: This Authorization does not permit the Provider to allow the copying of the records by any other copy service or business associate as defined by the Health Insurance Portability and Accountability Act "HIPAA". This Authorization does not permit disclosure of any information to any person, entity, provider or insurance company other than the representative copying of the records by a representative of **REPLICA**. Any and all Authorizations signed before this Authorization are revoked.

Right to Revoke: The Individual has the right to revoke this Authorization at any time by giving the provider a written notice of revocation of this Authorization. The Individual has the right to refuse to sign this Authorization. Such refusal will not affect the Individual's ability to obtain treatment, payment or eligibility for benefits. The Individual has received a copy of this Authorization. A copy of this Authorization is valid as the original.

Individual's Signature: _____ Date: _____