DONNIE
GAMACHE
ATTORNEY AT LAW

100 South Main Street, Suite B,
Summerville, S.C. 29483

Mailing Address: P.O. Box 550,
Summerville, S.C. 29484

Office: 843.821.8280
Office: 843.821.8289
Fax: 888.492.8289
clients@gamachelawfirm.com

AUTHORIZATION AND REQUEST TO RELEASE
ALL MEDICAL, EMPLOYMENT, AND OTHER INFORMATION
STATEMENTS AND REPORTS TO ATTORNEYS

TO: Any physician, hospital, medical clinic, laboratory, agency, or other health care institutions, insurance companies, accountants, governmental agencies, and/or employers or other individual firms or facilities having any information concerning the below referenced individual.

RE: Name: _____
Address:_____
SSN: _____
DOB: _____
DOA: _____

This is to request and authorize that Donnie Gamache, Attorney at Law, LLC, 100 South Main Street, Suite B, Summerville, South Carolina 29484, telephone (843) 821-8280, be furnished any and all medical, insurance, accounting, employment, or any other information of any type whatsoever which it might request concerning the above individual and to cooperate with it to the fullest extent in this regard.

I, the undersigned, have read the above and authorized any physician, hospital, medical clinic, laboratory, agency, or other health care institutions, insurance companies, accountants, governmental agencies, and/or employers or other individual firms or facilities to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it or as otherwise specified by law. No individual has coerced me into signing this authorization and I am providing this authorization under my own free will. I understand that once this information is received by the authorized person/organization, then this information may be subject to re-disclosure, and may no longer be protected by federal privacy laws.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If no date is specified, this authorization will expire twelve months from the date of signature.

HIPAA DISCLOSURE

I HAVE BEEN ADVISED OF MY RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) Privacy Regulations, 45 CFR § 164.508 AND I INTEND FOR THIS AUTHORIZATION TO SATISFY THE REQUIREMENTS OF HIPAA AND THE RULES AND REGULATIONS RELATING TO SAID ACT. IN THAT REGARD, I CERTIFY THAT I CONSENT TO THE RELEASE OF MY RECORDS TO MY ATTORNEY, THAT THE PURPOSE OF THIS REQUEST IS FOR MY ATTORNEY TO ASSIST ME IN MY LEGAL CLAIM, AND THAT THE RELEASE OF MY ENTIRE RECORD, OR SUCH PORTION AS MAY BE REQUESTED, IS THE MINIMUM DISCLOSURE NECESSARY TO SATISFY THIS REQUEST.

All prior authorizations are hereby revoked.

Date:_____ Signed:_____