



## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

In Compliance with HIPAA 45 CFR §164.508

Patient Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I give my expressed permission to \_\_\_\_\_ (name of insurer, provider or other lien holder) to disclose all protected health information for the purpose of healthcare lien resolution and subrogation to:

**Lien Settlement Solutions, LLC.  
1500 Robinson Street  
Orlando, FL 32801**

Information to be disclosed (**check all that apply**):

Complete conditional payment or claim summary pertaining to patient date of loss \_\_\_\_\_.

Entire patient medical records, treatment and patient history and any other documents relating to my medical care or treatment at any time.

Health plan description for insurers who may have made conditional payments for which subrogation may be required.

Only the following limited records or information: \_\_\_\_\_

This protected health information is being used or disclosed for the following purposes:

**If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.**

**I have the right refuse to sign this authorization. I understand that the authorizing the disclosure of my health information is voluntary. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I have the right to inspect or copy the protected health information to be used or disclosed under this authorization. Unless otherwise revoked, this authorization will expire on \_\_\_\_\_, or two years after the date of signature.**

**Finally, I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must send written notification to Lien Settlement Solutions, 1500 Robinson Street, Orlando FL 32814. I also understand that any written revocation will not apply to actions taken by the requesting person/entity prior to the date the notification is received.**

\_\_\_\_\_  
Signature of Participant or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Relationship of Personal Representative to Patient**  
(Please attach court approved documentation for representative.)