AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I hereby authorize the class of persons identified below to use and disclose protected health information from the records of:

   Patient's Name: _____Birth Date: _____

   Social Security No.: _____

   Class of persons authorized to disclose: All hospitals, clinics, physicians and other health care providers that have obtained or later obtain records of my past, present and future health care and treatment.

2. Copies of the following records shall be used and disclosed: Complete Medical Records and Billing Records or any subset thereof that is requested.

3. I understand that the records used and disclosed pursuant to 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; mental or behavioral health or psychiatric care; and/or occupational conditions.

4. I understand that copies of the records indicated above may be sent to any of the following: _____, or their agents, including but not limited to _____

5. I understand that the purpose of the use and disclosure is to develop claims and defenses in pending litigation.

6. I understand that I may revoke this authorization in writing at any time except to the extent that the Persons Authorized to Disclose have already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to the Persons Authorized to Disclose stating my intent to revoke this authorization.

7. Unless otherwise revoked, I understand that this authorization expires five years from the date of my signature below.

8. I understand that my health care providers may not condition treatment upon my completion of this authorization form.

9. I understand that, to the extent the recipient of this information is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal or Texas privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

10. I understand that I may inspect and copy the information to be used and disclosed pursuant to this authorization form before I sign this authorization form, if I ask to do so.

11. I understand that this authorization is voluntary and that I may refuse to sign this authorization form.

X _____ Date: _____

Signature of Patient or Legal Representative

_____ _____

Printed Name of Patient or Legal Representative

Representative's Authority to Act for Patient