Authorization for Use and Disclosure of Protected Health Information
Pursuant to the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA) (45 C.F.R. §164.508)

To: _____(Lien Holder/Disclosing Party)

Re: _____(Claimant/Injured Party and Date of Birth)

Purpose: This document will authorize the following person(s)/entity to represent me for purposes of resolving subrogation and/or reimbursement interests/healthcare liens, if any, in my personal injury claim. The entities and persons named below are authorized to request and receive from you any and all information related to this claim, and discuss, negotiate, and ultimately resolve this claim on my behalf. This authorization also applies to review and access to online websites containing my Protected Health Information (defined below), including but not limited to Mymedicare.gov.

Information to be Disclosed:

Healthcare lien/claim information, including but not limited to diagnosis and other procedural codes, as well as medical records, whether electronic or otherwise, regarding enrollment status, and/or any payments made, or medical care performed or paid for by the healthcare lien/claim holder relating to the injury-related charges for the period beginning with the date of incident ("Protected Health Information").

Person(s)/Entity Authorized to Receive and Use Protected Health Information:

The Garretson Resolution Group, its agents, employees, affiliates, subsidiaries, or representatives ("GRG").

Mailing Address:
Garretson Resolution Group
4064 Colony Road, 2nd Floor
Charlotte, NC 28211

I hereby direct any healthcare lien/claim holder, its contract representative and/or the plan/claims administrator (the "Disclosing Party") to release my Protected Health Information, described above, to GRG. I understand that GRG may re-disclose this information in its efforts to resolve my healthcare liens/claims. Furthermore, I understand that my Protected Health Information will no longer be protected by Federal privacy regulations. Therefore, I release the Disclosing Party from all liability arising from the disclosure of my Protected Health Information under this Authorization.

Right to Revoke:

I understand that I am entitled to inspect the terms of this Authorization, and I may request and receive a copy of the same if the Disclosing Party requested this Authorization. I understand that I may inspect or request copies of my Protected Health Information disclosed by this Authorization. I understand that I may revoke this Authorization by notifying the Disclosing Party or authorized entities in writing, knowing that previously disclosed information would not be subject to my revocation request.

I understand refusal to authorize disclosure of my Protected Health Information will have no effect on enrollment, coverage, or the amount paid, or to be paid, for the health services I receive.

This authorization will expire two (2) years from the date following the resolution of my healthcare lien/claim, and may be signed via electronic signature, facsimile signature, or original signature all of which will be legally binding as if it was the original signature.

Claimant/Injured Party Signature	Print name	Date

OR

Personal Representative Signature	Print name, and Title (based on authority to act) (*i.e.*,guardianship /conservatorship letters of authority, powers of attorney, etc. attached)	Date