

**ABRAMS LANDAU, LTD.
MEDICAL AUTHORIZATION**

I, _____ (Date of Birth _____, SSN: _____) hereby authorize the release of my entire record, including all medical documentation and other information which may be in the possession of any physician, insurer, surgeon, hospital, ambulance service or nurse, to any representative of Abrams Landau Ltd. regarding my injuries, medical history, and physical & mental condition from five years prior to _____, to the present. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for drug and alcohol abuse.

Upon presentation of this authorization (or a photocopy), you are authorized to release a copy of these records to any representative of Abrams Landau Ltd. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal confidentiality rules.

The purpose of this disclosure is at my request for purposes of litigation and this Medical Authorization shall be deemed to comply with the requirements of the Health Insurance Portability and Accountability Act (45 CFR 164.508).

This Medical Authorization shall expire upon final resolution of my pending claim and / or litigation handled by Abrams Landau Ltd. I understand that I may revoke this Medical Authorization at any time by sending written notice to the medical providers and to Abrams Landau Ltd. I understand that my revocation will not apply to information that has already been released in response to this authorization.

Patient's Signature

Date