The firm of Meyer Christian & Associates

AUTHORIZATION TO RELEASE PROTECTED HEALTH CARE INFORMATION

I understand that the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR §165.508, protect my medical records from being released without my permission. I authorize my healthcare provider, medical group, hospital or doctor to release to MEYER, CHRISTIAN & ASSOCIATES, INC., or any of its representatives, all medical billing records that they request.

I am giving permission to MEYER, CHRISTIAN & ASSOCIATES, INC. to obtain medical billing records related to treatment I have received for a physical condition or injury caused by a third party I have a claim against. This authorization expires three years from the date of my signature.

I understand that I have the right to revoke this authorization by sending a signed, written notice of revocation to MEYER, CHRISTIAN & ASSOCIATES, INC. My revocation would prevent MEYER, CHRISTIAN & ASSOCIATES, INC. from any further access to or use of my records except to the extent that they have already taken action in reliance on this authorization.

You or any other healthcare provider may not deny treatment or change payment based on whether or not I have signed this authorization. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure to my attorney or to an insurance adjuster handling my claim. I understand that as a result of this disclosure any information revealed may no longer be protected by the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA).

Signature: _____ **Date:** _____

Parent, guardian or representative ☐ Name: _____

NOTICE AND ACKNOWLEDGEMENT OF MY OBLIGATION TO REIMBURSE MY HEALTH CARE PROVIDER

I understand that both my health plan and California Civil Code Section 3040 require me to repay my health care provider for expenses incurred on my behalf in the course of providing medical treatment to me as a result of an accident or injury for which a third party is liable. I agree that I am obligated to reimburse my medical provider out of any money I may recover from the responsible party or from any insurance they may have.

I understand that if I do not recover any money from the responsible party or from their insurance, I do not have to reimburse my medical provider. I understand that my obligation to reimburse only arises if I am successful in obtaining a recovery from the responsible party or from any insurance they may have.

I direct and authorize my attorney to fulfill this obligation with the proceeds of any settlement, award or judgment I may recover. If I do not have an attorney, I understand and acknowledge that I am personally responsible for the medical charges and I will reimburse them from any settlement, award or judgment I may recover.

Signature: _____ **Date:** _____

Parent, guardian or representative ☐ Name: _____

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