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AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

(Pursuant to the Health Insurance Portability and Accountability Act - HIPAA)

I, _____, (Date of Birth: _____, SSN _____), hereby authorize and direct _____, that any member of the Magistrate Selection Committee formulated by order of Chief Judge Rebecca R. Pallmeyer, be permitted to have access to, examine and copy the entire chart or file, including: medical history; operative reports; discharge summary; radiology reports, images, and films; pathology/lab reports and slides; lab reports; consultations; and psychological testing/assessment; and bills for treatment or services, kept in connection with the diagnosis and treatment of _____. Further, I authorize any of my treating physicians or psychologist to discuss in person or over the phone any aspect of my medical status and/or treatment.

This information is to be used solely for the purpose of the screening of the aforesaid candidate for the position of magistrate judge.

I recognize that I have the right to inspect and copy the information that is to be disclosed and that my refusal to consent to the release of the information specified above will prevent disclosure of such information to the facility or person named herein. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected, in accordance with The Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164. Further, I understand that I have the right to revoke this authorization in writing at any time.

Unless otherwise specified, this authorization is valid up to and including six months from the date of signature below. Records obtained will either be destroyed or returned to the provider at the end of the evaluation process

_____

Signature: Patient or Legally Authorized Patient Representative *Date of Signature*

_____

Signature of Witness *Date of Signature*