Starr and Associates, Inc.
1600 East Beltline Ave NE, Suite 217
Grand Rapids, MI 49525
Phone: 616-363-4500 Cell: 616-318-4882 Fax: 616-363-5334

AUTHORIZATION TO DISCLOSE INFORMATION

TO: Dr. ____

I voluntarily authorize and request disclosure (including paper, oral and electronic interchange):

OF WHAT ***All my medical records;*** **also education records and other information related to my ability to perform tasks. This includes specific information to release:**

1. All records and other information regarding my treatment, hospitalization and outpatient care for my impairment(s) *including*, and *not limited to:*
   X_Psychological, psychiatric or other mental impairment(s)
   X_Drug abuse, alcoholism or other abuse
   __Sickle cell anemia
   __Records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis or gonorrhea and the HIV virus aka AIDS.
   __ Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living & work.
3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations and any other records that can help evaluate function; also teacher's observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM: Karen Starr **or any person designated by her**

PURPOSE To complete a Medicare Set-Aside Allocation.

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

φ I authorize the use of a copy (including electronic copy) of this form for disclosure of information described above.

φ I may write to Karen Starr and my sources to revoke this authorization at any time.

φ Karen Starr will give me a copy of this form if I ask, I may ask the source to inspect or get a copy of material to be disclosed.

- I understand and agree to 3rd party re-disclosure of my records.

φ **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

Printed Name: ______________________________

Signed Name: ______________________________

SSN: ______________ DOB: ______________

Date Signed: ______________ Phone: ______________

Address: ______________________________

____

Name of Parent or Guardian signing if minor or necessary:

____
Signed:

____
Printed:

This general and specific authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational and other information under P.L. 104-191 ("HIPPA"); 45 CFR parts 160 and 164; 42 U.S.Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7322; 38CFR1.475; 20 U.S. Code section 1231g ("FERPA"); 34 CFR parts 99 and 300; and State Law