AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____	_____
Name of Patient	Date of Birth
_____	_____
Street Address	City, State, Zip Code

Authorizes:

William G. Schwab, Trustee for the
Estate of Pottsville Internists
Associates, Inc.
P.O. Box 269
Pottsville, PA 17901

To Release Protected Health Information To:

_____
_____
_____
_____
_____

Information To Be Released: Entire Medical Record.

In compliance with Pennsylvania Statutes, which require special permission to release otherwise privileged information, please release records pertaining to: [✓] Any diagnosis or treatment for alcoholism and/or drug abuse or dependence; [✓] Any diagnosis and/or treatment concerning my mental health/rehabilitation; [✓] Any HIV related treatment and/or testing - Positive or Negative; [✓] Any ethanol and/or drug toxicity screening.

For the Following Dates: All available dates.

Purpose for Need of Disclosure: Pottsville Internists Associate, Inc's Bankruptcy and its termination of operation.

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Your rights with respect to this authorization.

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Trustee at P.O. Box 269, Pottsville, PA 17901. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdraw, I can contact the Trustee at P.O. Box 269, Pottsville, PA 17901.

I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____	_____
Patient's Signature	Date

(If signed by person other than patient, state relationship and authority to do so)

Patient is: [ ] a Minor, [ ] Incompetent, [ ] Disabled, [ ] Deceased

Legal Authority* : [ ] Custodial Parent, [ ] Legal Guardian, [ ] Executor of Estate of Deceased,
[ ] Power of Attorney for Healthcare, [ ] Authorized Legal Representative
* Please provided supporting documentation for your elected legal authority.

_____	_____
Witnessed By:	Date