

## AUTHORIZATION TO DISCLOSE MEDICAID INFORMATION

To:

I, the undersigned, hereby authorize and request the above-named entity to disclose to the agents or designees of the law firm of Nelson Mullins Riley & Scarborough, LLP, and/or to The Marker Group, Inc., any and all records, since \_\_\_\_\_ **to present**, containing Medicaid information, including those that may contain protected health information (PHI) regarding \_\_\_\_\_, including records created after the date of signature. This authorization should also be construed to permit agents or designees of Nelson Mullins Riley & Scarborough, LLP and/or The Marker Group, Inc. to copy, inspect and review any and all such records. Records requested may include, but are not limited to:

all Medicaid records, including explanations of Medicaid benefit records and claims records; any statements, communications, pro reviews, denials, appeals, correspondence, reports, questionnaires or records submitted in connection with claims; all reports from physicians, hospital, dental providers, prescriptions; correspondence, test results and any other medical records; records of claims paid to or on the behalf of \_\_\_\_\_; records of litigation and any other records of any kind with the exception of mental health records. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

A copy of this authorization may be used in place of and with the same force and effect as the original. The purpose of this authorization is for civil litigation.

### NOTICE

- **The individual signing this authorization has the right to revoke this authorization at any time, provided the revocation is in writing to Nelson Mullins Riley & Scarborough, LLP and/or The Marker Group, Inc.; 13105 Northwest Freeway, Suite 300, Houston, TX 77040, except to the extent that the entity has already relied upon this Authorization to disclose protected health information (PHI).**
- **The individual signing this authorization understands that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization.**
- **The individual signing this authorization understands that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations.**
- **The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.**
- **This authorization shall expire one year from the date of execution.**
- **This authorization does NOT authorize the requesting party (Nelson Mullins Riley & Scarborough, LLP, The Marker Group, Inc. or their agents) to discuss the patient's care, treatment or prognosis with recipient of this authorization.**

\_\_\_\_\_  
Name of Individual

\_\_\_\_\_  
Signature of Individual or Individual Representative

\_\_\_\_\_  
Former/Alias/Maiden Name of Individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Individual's Date of Birth

\_\_\_\_\_  
Name of Individual Representative

\_\_\_\_\_  
Individual's Social Security Number

\_\_\_\_\_  
Description of Authority

\_\_\_\_\_  
Individual's Address

I have read this Authorization and understand that it will permit the entity identified above to disclose PHI to  
The Marker Group, Inc. and/or Nelson Mullins