

LAWSUIT CASH

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, authorize disclosure of my protected health information (“PHI”) as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) as follows:

1. Classes of Persons Authorized to Disclose My Protected Health Information: I authorize my attorney whom I have employed to represent me in a legal action regarding a personal injury claim and/or any of his/her associates having any PHI about me to disclose any and all of my PHI as provided under this authorization. I authorize my attorney or his/her associates to rely upon a photocopy or facsimile copy or other reproduction of this authorization.

2. Classes of Persons Authorized to Receive My Protected Health Information: I authorize my attorney to disclose my PHI under this authorization to **LAWSUIT CASH** its affiliates and any of their directors, officers, employees, agents, independent contractors, consultants, underwriters, lenders, financing entities, capital providers or other representatives (each, an “Authorized Recipient”).

3. Protected Health Information Authorized for Disclosure and Purpose of Disclosure: This authorization shall apply to any and all of my health and medical data, information and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient (1) to analyze, assess, evaluate or underwrite my sustained injuries, current medical condition, pre-existing medical condition, and medical treatments received in connection with my personal injury claim for the purpose of evaluating such information for the possible sale of contingent proceeds of any potential monetary settlement.

4. Expiration: This authorization shall remain valid until, and shall expire, one year after the date of the settlement and/or conclusion of my personal injury claim.

5. Right to Revoke Authorization: I acknowledge and understand that I may revoke this authorization at any time with respect to any attorney representing me by notifying such attorney in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such attorney; provided, that, any revocation of this authorization shall not apply to the extent that the attorney has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

6. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization. No HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the “HIPAA Privacy Regulations”). I further understand that, as a result of this authorization, there is the potential for my PHI that is disclosed by my attorney to an Authorized Recipient to be subject to re-disclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

Signature of Individual

Date

Print or Type Name of Individual