Clear Form

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____
Name of Patient (List Other Names Used) Date of Birth

[1.] I hereby authorize: _____
Name of Facility with Records / Disclosing Party

[2.] To disclose to: _____
Name of Requesting Party (Requester): Insurance Carrier / Third Party Administrator / Self-Insured Employer / Attorney Firm

and/or their attorneys, through **Copy Quest Legal Services, Inc.** their agent, to review, inspect, and/or photocopy **any and all of the following from any and all dates** which are in your possession or control:

[ ] Medical Records, to include but not limited to: medical files, reports, charts, graphs, notes, tests, x-rays, MRI's, billings and laboratory reports.
[ ] Employment Records, to include but not limited to: personnel file, medical and insurance, pension benefit records and wage records.
[ ] Union Records
[ ] Police, Prison or Probation Records
[ ] Scholastic Records
[ ] Insurance and Claim Records
[ ] Non-privileged, to include but not limited to transcripts, discovery docs, pleadings, medical records, injury and accident reports, final determinations, deposition transcripts, witness statements, pleadings and other materials not considered protected by the attorney-client priviledge or work product doctrine.

SENSITIVE INFORMATION: I hereby authorize the release of information concerning:

[ ] Psychiatric and Mental Health Information
[ ] Alcohol and/or Drug Information
[ ] Sexually Transmitted Disease Information
[ ] HIV and/or AIDS Information
[ ] Genetic Records

Date Range of Records to be released _____ to _____

The health information authorized on this form will be used for the following purpose only:
Discovery for Workers' Compensation claim or Liability.

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ or for ONE full year from date of signature.

REVOCATION: This authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt but will not be effective to the extent that the requester or others have acted in reliance upon this authorization. Written revocation is to be sent to those parties listed on line 1 and 2 above.

PROHIBITION OF USAGE, TRANSFER OR REDISCLOSURE OF INFORMATION: Except as required by state or federal laws, use of information released for other than the stated purpose or redisclosure or transfer of this information to any person or entity not named herein is prohibited. An additional written authorization must be obtained for any proposed new use of the information or its redisclosure or transfer of such information. Authorized information may be subject to redisclosure by the recipient and no longer protected by the privacy regulations.

I understand that I have the right to receive a copy of this authorization. A copy of this authorization shall be considered as valid as the original.

I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

_____ _____ _____
Signature Print Name Date

_____
If Signed by Other than Patient, Indicate Relationship