AUTHORIZATION TO RELEASE, USE AND DISCLOSE PROTECTED INFORMATION
45 CFR 164.508 & 164.512 (HIPAA)

NAME: DATE OF BIRTH:

ADDRESS: SS#:

CLAIM #:

I authorize the disclosure and release of any and all protected health information including but not limited to: WRITTEN MEDICAL RECORDS: any and all medical records, all in patient and outpatient charts and records, hospital charts and records, doctor and nurse notes, emergency room records, correspondence, memoranda, physical therapy and rehabilitation records, patient questionnaire forms, patient history forms, social service records, laboratory records and diagnostic reports. PRESCRIPTION RECORDS: any and all prescription records, original doctor's prescription forms, refill records and pharmacy records. BILLING: any and all billing records, including itemized statements of charges, payments, all insurance records, including all claims, claim forms, correspondence, payments and reports. EMPLOYMENT RECORDS: any and all employment records including wage information and personnel documents. BUREAU RECORDS: any and all Bureau of Workers' Compensation records for any and all workers' compensation claims. INSURANCE RECORDS: any and all documents regarding any insurance claim involving a physical injury including, but not limited to, all medical records, correspondence, medical history, police reports, payment ledgers and all other documents contained in the claim(s) file This authorization applies to all medical records, injuries, medical history, employment and physical condition regardless of the time of occurrence both prior to and subsequent to my signature on this form regardless of time of occurrence.

HIV, Mental Health, and Drug & Alcohol Information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.

Do not Release: _____ HIV _____ Mental Health _____ Drug & Alcohol

This protected health information is disclosed for the following purpose: **Workers' Compensation Claim**

This information will be used for the purpose of verifying, evaluating and/or negotiating the individual's claim. This information is not required for obtaining treatment.

You are authorized to release the above records to the following: Lackawanna Insurance Group and its agent(s) for the purpose of medical record procurement.

I have the right to revoke this Authorization, in writing, by sending written notification to the covered entity. I understand that my decision to revoke the authorization may result in a denial of my workers' compensation claim for failure to comply with a medical record request, but it will not affect my ability to obtain treatment from any covered entity. I further understand that a revocation is not effective to the extent that you have relied upon my authorization to disclose protected health information prior to revocation. In addition, I understand that the information may be re-disclosed and no longer subject to protection. I understand that I have the right to:

- Inspect or copy the individually identifiable health information to be disclosed.
- Refuse to sign this authorization, subject to any possible sanctions imposed by the Pennsylvania Workers' Compensation Act and its Regulations.
- That I am entitled to a copy of this completed authorization form.

This form also constitutes authority for you to produce and make photostatic copies of all such records, and to forward same by mail to the approved referenced representative. A photostatic copy of this Authorization shall have the same effect as the original.

This authorization shall remain valid until the claim has been legally concluded for which these records are sought.

_____ _____

Signature of Individual/Legal Representative **Date**

_____ _____

Printed Name of Individual/Legal Representative **Relationship to Individual**