

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND INFORMATION

EMPLOYER'S NAME:			
EMPLOYEE'S NAME:	DATE OF INJURY:		
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	

TO: ANY AND ALL HEALTH CARE PROVIDERS

I hereby authorize you, any member or employee of your office or association, as well as any hospital, by which I have been treated, to release complete and legible copies of any and all information concerning my physical and mental condition, care and treatment to the following for the purpose of administering my claim:

FARA an Avizent Company, and/or their duly authorized agents or employees.

This Authorization includes, but is not limited to: medical reports, clinical notes, nurses' notes, written or oral communication concerning my history of injury, subjective and objective complaints, ability to return to work, date of maximum medical improvement, physical impairment, physical restrictions and limitations, causation of injury and interpretation of diagnostic tests. Additional reports and notes covered under this request may include but are not limited to: x-rays, x-ray reports or interpretations, other diagnostic tests (including a copy of the report), diagnosis and prognosis, emergency room records or logs, history and physical examination report, laboratory reports, tissues, tissue slides, or tissue committee reports, report of operation logs, progress notes, doctors' orders, nurses' notes, physical therapy records, admission and discharge summaries, psychiatric reports and records, and all out-patient records, pharmacy/prescription records, hospital bills, bills for the services rendered, bills for medication, and any other documents, records or information in your possession regarding my past, present and future physical and mental condition.

Notwithstanding the foregoing, The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of a family member of the individual, except as specifically a permitted. To comply with this law, do not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assisted reproductive services.

I hereby waive any laws, regulations and rules of ethics, which might prevent any hospital, doctor or other person who has treated or examined me in a professional capacity, or otherwise, from releasing the information and records requested.

I appreciate your cooperation in the release of the information and records requested and I hereby hold you harmless from any liability in connection with the disclosure of the medical records and information requested.

A photo static copy and/or facsimile of this authorization, which contains my signature or electronic signature, shall be considered as effective and valid as the original and shall be honored by those to whom it is sent or provided.

All costs for said copies are to be directed to FARA an Avizent Company,

I understand the following:

1. Signing this form is not a condition of receipt of worker's compensation benefits. I have signed this Authorization voluntarily.
2. I have the right to revoke this Authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
3. The information released in response to this Authorization may be re-disclosed to other parties.
4. This Authorization will expire seven (7) years from the date of execution, or such shorter time as may be required by law.

EMPLOYEE'S SIGNATURE

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE

WITNESS SIGNATURE

ADDRESS

CITY / STATE / ZIP

DATE