# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS PURSUANT TO 45 CFR 164.508 (HIPAA)

Patient Name: ___________________________________________ Social Security No.: ______-______-______

Date of Birth: ______/______/________ Date of Injury/Onset of Illness: ______/______/________

TO: ANY PHYSICIAN, SURGEON, DENTIST, HOSPITAL, REHABILITATION/CONVALESCENT/CUSTODIAL FACILITY, PHARMACIST, AMBULANCE, NURSE, OTHER HEALTH CARE PROVIDER OR INSURANCE COMPANY.

I, _____________________________________________, authorize you to disclose and release the following protected health information. All inpatient admissions, all ER visits, outpatient clinic notes, diagnostic testing, radiology films, consults, doctors' orders, progress notes, nurses' notes, laboratory testing, social service records, reports, correspondence, consultations, memoranda, treatment plans, admission records, discharge summaries, medical summaries, diagnoses, and/or writing of any kind.

Also, please disclose and release the following protected health care information (only if checked below):

Drug and alcohol records ________ Communicable disease HIV and AIDS Records ______

Mental Health Records (not including Psychotherapy Notes) ______

This protected health information is disclosed for the following purposes: verifying, evaluating, negotiating and/or other pertinent legal uses, with respect to the patient's insurance claim.

***YOU ARE AUTHORIZED TO RELEASE THE ABOVE RECORDS, OR COPIES THEREOF, TO ANY REPRESENTATIVE OF MRM WC POOLED TRUST (CARRIER) AT THE FOLLOWING ADDRESS: 1603 CARMODY COURT, BLAYMORE II, SUITE 403, SEWICKLEY, PA 15143.***

I further authorize any health care provider to release all tests, reports, notes (excluding psychotherapy notes) and all other information concerning my medical and/or psychological conditions and/or treatment and to meet with, discuss and/or to correspond and report directly to Carrier or any representative(s) it may designate to discuss my medical and/or psychological condition(s) or treatment.

I also authorize the provider of treatment to: 1) communicate directly with my Employer, Carrier and/or its representatives on his/her own initiative, if necessary, concerning my medical and/or psychological condition(s) and/or treatment, and 2) consult with my Employer, Carrier and/or its representative(s) upon request provided that the responsibility for any charges for such consultation will lie solely with the requesting party of the consultation. I expressly waive all rights that I may have to be notified of these communications and to be present at consultations.

The purpose of such communications, correspondence, consultations, and meetings is the same as set forth above with respect to my authorization for the disclosure of protected health information.

This authorization shall be in force and effect until the later of one year from the date signed or the date the claim has been legally concluded at which time this authorization expires.

I have the right to revoke this authorization, in writing by sending written notification to you with copy to MRM Trust (Carrier) at the above address. I understand that a revocation is not effective to the extent that you have relied on my authorization to disclose protected health information.

I further agree that a photocopy or facsimile copy of the Authorization shall be valid and effective just as the original.

I understand that I have the right to: 1) Inspect copy of the individually identifiable health information to be disclosed; 2) refuse to sign this authorization; 3) receive a copy of this Authorization upon request.

X ____________________________________ ____________________________________

Signature of Patient or Personal Representative Printed Name of Patient or Personal Representative

X________________________ ____________________________________________

Date Description of Personal Representative's Authority to Sign for Patient (If applicable)