AUTHORIZATION TO RELEASE ALCOHOL, DRUG, PSYCHIATRIC AND HIV RELATED INFORMATION

Full Name of Patient: _____ Date of Birth: _____
In accordance with state and federal statutes and regulations, I authorize _____
of _____ ("Record Holder") to release my complete health information, including any and all information and records in the possession of Record Holder, whether rendered prior to or after this authorization, pertaining to ("Information"):

1. Diagnosis, treatment and education related to drug and/or alcohol abuse
2. Communicable infectious diseases, including sexually transmitted diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency virus ("HIV")/Acquired Immune Deficiency Syndrome ("AIDS") and
3. Psychiatric and other mental health services.

I allow the Records Holders to give my information to the following individuals or entities ("Benefit Managers"): the employer names below, MRM WC Pooled Trust, their benefit plan or claims administrator(s), their related companies, contractors, investigators, attorneys, and service consultants, authorized union representatives, health care providers treating or evaluating me or my claim, and other individuals or entities involved in administering, evaluating, analyzing and managing the plan or my claim.

I allow the Benefit Managers to use and give out the information only to evaluate, analyze, manage and/or administer a claim for short term disability benefits, long term disability benefits, salary continuation, leave under the federal Family and Medical Leave Act, local and state leave laws, workers' compensation and/or any other health benefit program or leave benefit offered by and through my employer ("Benefits Program"). I also allow the Benefits Manager to give my information to any other person or entity if needed to find out whether I am eligible for benefits, to manage by claim, or to run the Benefits Program. I expressly waive any and all rights that I may have to be notified of these communications. The Benefits Manager will tell those receiving the information that the Information is confidential.

This authorization shall expire one hundred and twenty (120) days after the date appearing below or one hundred and twenty (120) days after my final treatment, whichever is later, unless law requires a shorter period. If I change my mind before that time, I can tell my Record Holder in writing that I do not want them to share any more Information. If I tell them in writing to stop sharing Information, it will not change any actions they took before I told them.

If I do not sign this form, it will not affect how my health care providers treat me. However, if I do not sign, the Benefits Managers may not be able to review my claim and cannot find out whether I am eligible for benefits. This may result in denial of my request for benefits. I know I can see or copy the records given to the Benefits Managers.

The Information released under this authorization can be submitted to the Records Holders electronically, by phone or fax, or by mail. I agree that a copy of this form may be treated as a signed original.

Claimant's Name: _____ Date: _____

_____ _____
Claimant's or Legal Representative's Signature Legal Representative's Name & Relationship

Employer's Name: _____

(A COPY OF THIS FORM MUST BE PROVIDED TO THE CLAIMANT.)