macro-pro

HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECORDS

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 **Macro-Pro 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:

_____ ___/___/____ _____
Name of Patient (List Other Names Used) **Date of Birth** **Last 4 of SSN**

- **Medical records**, to include but not limited to: Medical files, reports, charts, graphs, notes, tests, x-rays, MRI's, billings and laboratory reports.
- **Employment and/or Union records** to include but not limited to: Personnel file, medical and insurance, pension benefit records and wage records.
- **EDD Disability and Unemployment Records**
- **Police, Prison or Probation Records**
- **Scholastic Records**
- **Insurance and Claim Records**
- **Pharmacy Records**

SENSITIVE INFORMATION: By initialing below, I hereby authorize the release of information concerning:

____ **Psychiatric and Mental Health Information** ____ **HIV and/or AIDS Information**
Initial **Initial**

____ **Alcohol and/or Drug Information** ____ **Genetic Records**
Initial **Initial**

____ **Sexually Transmitted Disease Information**
Initial

Date Range of Records to be Released____/____/_____to _____

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

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 line 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. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this form.

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.

_____ _____ _____
Signature **Print Name** **Date**

_____
If Signed by Other than Patient, Indicate Relationship

MEDICAL HISTORY

Employee	Employer
Address	Date of Injury
City, State Zip code	Daytime Telephone Number

Please list below all hospitals and doctors including medical doctors (MD), chiropractors (DC), osteopaths (DO), physical therapists, psychologists, psychiatrists, or any other medical care provider you have seen in the last 10 (ten) years.

Name Address and Phone #'s of Providers	Treatment Date(s)	Type of Treatment