

AUTHORIZATION FOR RELEASE OF RECORDS

RECORDS SUBJECT:

Individual:

Social Security Number

Date of Birth:

SERVICE PROVIDER:

Requesting Records from

REQUESTED BY:

Pacific Compensation Insurance Company

Disclosure of records will be provided to:

representing the above Requested By: Pacific Compensation Insurance Company

The Service Provider is directed to make available for copying all records pertaining to the Individual. Including, but not limited to, any and all files, photographs, video and/or audio tapes and/or records for all injuries or conditions in the Service Provider's possession or under the Service Provider's control that is held for any purpose. Nothing shall be removed, deleted, altered or withheld.

If additional items are to be disclosed or not disclosed by Service Provider, you *must* check ALL appropriate boxes.

Release	Do NOT
Records	Release
<input type="checkbox"/>	Records
	<input type="checkbox"/>

All medical records during the care and treatment, hospitalizations, evaluations, testing, examination, office visits, emergency room, lab testing. Including, but not limited to, nurse's notes, operative and pathology reports, emergency room records, surgery records, physical therapy records, inpatient and outpatient charts, MD progress notes, consults, MD orders, discharge summary, prescriptions, EKG, and EMG, EEG.

(continued on page 2)

- | Release
Records | Do NOT
Release
Records | |
|--------------------------|-------------------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | All billing records, itemized statements of the billing charges, pertaining to the care, treatment, and examination, showing all charges, expenses, costs and payments. |
| <input type="checkbox"/> | <input type="checkbox"/> | All Original X-ray films, MRI films, CT Scans, and film reports. |
| <input type="checkbox"/> | <input type="checkbox"/> | All psychiatric, drug and/or alcohol treatment, evaluation, treatment, abuse testing, counseling, rehabilitation records.
INITIAL HERE _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | All mental health information consisting of, but not limited to, all notes, records and reports of psychotherapy diagnosis, evaluation and treatment. INITIAL HERE _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | All employment records, including, but not limited to, payroll records, absenteeism or time off, benefits, applications, and claim records, applications for employment, work absentee records, time cards, incident reports, W-2's, 1099's, pre-employment exam records and employee progress records. |
| <input type="checkbox"/> | <input type="checkbox"/> | Any and all records, report cards and transcripts, to include all office disciplinary and scholastic records, class schedules, absentee records, medical records, incident reports, teacher comments and any records having to do with physical education or participation in sports or extra-curricular activities from the first date of enrollment to the present. |
| <input type="checkbox"/> | <input type="checkbox"/> | All Insurance records, including correspondence, payments, photographs, underwriting and claim records. Including, but not limited to, copies of policies involved, payments made there under, medical records submitted by the company or other physicians. Any and all documents, including, but not limited to, Declarations of Coverage, which evidence compliance with California Financial Responsibility Laws at the time of the accident. |
| <input type="checkbox"/> | <input type="checkbox"/> | All HIV test results or any related AIDS virus information.
INITIAL HERE _____ |

At the request of the individual this information will be used for the purpose of aiding the individual and his or her attorney in establishing the liability, nature and extent of a claim for injuries and disabilities and to establish benefits, expenses, compensation and damages. The information provided may be disclosed by the Attorney or

To other parties and/or treating/evaluation physicians for the purpose of prosecuting or defending any claim for which the Attorney has been engaged to pursue or defend. This Authorization does not permit the Service Provider to allow the copying of records by any other copy service or business associate as defined by the Health Insurance Portability and Accountability Act (HIPAA). This Authorization does not permit disclosure of any information to any person, entity, provider or insurance company other than the copying of the records by a representative of

Any and all Authorizations signed before this Authorization are revoked.

Pacific Compensation Insurance Company designates and authorizes as his/her representative to pursue any and all legal remedies necessary to compel the production of records from the Provider.

A copy of this Authorization is as valid as the original; the original is not required to be shown. The Individual has the right to revoke this Authorization at any time by giving the Provider written notice of revocation of this Authorization. A copy of this signed Authorization will be given to the Individual after it has been signed. The Individual has the right to refuse to sign this Authorization. The provider may not condition treatment, payment, enrollment or eligibility for benefits on whether the Individual signs the Authorization. This authorization shall expire three years from the date of execution below unless a different date is specified here

Date: _____
Individual's signature or Representative

Date: _____
If signed by other than Individual indicate relationship (Parent, Guardian or Conservator)

This authorization was created in 14-point type in accordance with California Legislature Assembly Bill 715.

