AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____

Patient Address: _____

Date of Birth: _____

Social Security No: _____ Medical Record No.: _____

I, _____, (worker/patient full name, please print) hereby authorize and request disclosure of all protected information to aid Care West Insurance Company and its agents, attorneys and subsidiaries in establishing the liability, nature, and extent of a claim for injuries or disabilities and to establish benefits, expenses, compensation and damages. I expressly request that the designated record custodian of all covered entities under HIPAA, disclose full and complete protected medical information to the organization identified, including the following:

- All medical records, meaning every page in my record including but not limited to office notes, room treatment, clinical charts, reports, progress notes, nurse's notes, social worker records, treatment plans, admission records, test results, questionnaires, photographs, video's, telephone messages and records received from other medical providers
- All physical, occupational and rehab requests, consultation and progress notes
- All Medicare or Medicaid records
- All pharmacy and prescription records
- All lab, histology, cytology, pathology, immunohistochemistry records, radiology reports and films, NCM, MRI, Ct EMG, Cardiac Cath, videos, CDs, films, reels and reports.
- All psychological or psychiatric care/visit records for any visit or mental health care.
- All employment, personnel or wage records.
- Specific consent to any and all HIV and HEP C medical and HIV and HEP C related information under the conditions of this form

This consent is subject to revocation by the undersigned in writing at any time by notifying the above requestor, except to the extent that action has been taken in reliance herein. This authorization shall terminate at the date of resolution of my claim absent express revocation.

I understand I have a right as a patient to review the disclosed information by requesting it from the organization providing it.

I hereby release all parties from any and all legal liability that may arise from the release of this information to the party(s) named above. This is informed consent for the release of records. A photocopy of this original shall be deemed as valid to the original.

Patient Signature: _____ Date: _____
Patient Name (please print): _____

Patient Representative: _____ Relationship: _____ Date: _____
Representative Name (please print): _____