OccuSure CLAIMS SERVICES

HIPAA Compliant Authorization for Release of Protected Health Information

_____	_____
Employee Name	Address (city, state, zip)
_____	_____
SS#	Date of Birth

I hereby authorize any health plan, physician, health care professional, hospital, clinic, doctor's office, chiropractor, physical therapist, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years to disclose my entire medical record. This release is valid proof of consent for any medical provider as stated above to disclose protected health information for _____.

Employee Name

To: OccuSure Claims Services at 1885 General George Patton Drive, Franklin, TN 37067

Fax # 877-622-7871 Phone # 615-373-0500 or 877-622-7870

For the following purpose: **Administration of Occupational Injury Benefits**

This release of information authorization is valid for the: Entire Medical Record

This authorization is valid for one year after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked.

I, the undersigned, have read the above and authorize the staff of any health care provider, pharmacy, doctor's office, physician, laboratory, radiologist, chiropractor, physical therapist, or hospital to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used to disclose pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the applicable provider and its parent companies from all liability and damages resulting from the lawful release of my Protected Health Information.

_____	_____	_____
Date	Signature of patient/employee	Relationship