

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

***This medical authorization form complies in all respects with HIPAA.**

TO: _____

You are authorized and requested to give to _____ (hereinafter "Employer"); Johnston and Associates, DBA OccuSure Claims Services and the designated workers compensation insurance carrier (hereinafter "Insurer"); or their representative counsel; any information or opinion they may request regarding any physical condition and any treatment which has been rendered to me, including but not limited to diagnosis and prognosis, and allow the representatives and/or agents of Employer, Insurer, or their representative counsel to see and copy any and all records available, including but not limited to x-rays, regarding my condition and treatment and/or all of my hospital records and charts. I understand that the Employer, Insurer, or their representative counsel is requesting this information in connection with a workers' compensation matter in which I am involved. I also understand that Employer, Insurer, or their representative counsel will be responsible for the charges incurred in obtaining this information.

The Employee also expressly and unequivocally consents to allow the representatives and/or agents of Employer, Insurer, or their representative counsel; to have direct verbal or written contact and communication with all treating physicians, informally and without the employee present, regarding any and all confidential information related to the Employee's health disclosed or gained through the physician-patient relationship, regardless of the relation of said information to the alleged workers compensation claim. This authorization is valid for five (5) years from the date of execution.

I understand that I have the right to revoke this authorization in writing; however, in order to revoke this authorization I must give written notice of my intent to revoke this authorization to the Employer, Insurer, or representative counsel at least thirty (30) days prior to the date the revocation is to take effect. I also understand and agree that any information used or disclosed pursuant to this authorization may be subject to redisclosure by Employer, Insurer, or representative counsel and no longer protected by law.

I understand that I may inspect or copy the protected health information received by Employer, Insurer, or representative counsel procured exclusively as a result of this authorization by submitting a written request to Employer, Insurer, or representative counsel.

I further understand that I do not have to sign this authorization; however, I have freely signed this authorization. I also acknowledge that I have received a signed copy of this authorization. I have read, fully understand, and heretofore consent to all aspects of this authorization, as evidenced by my signature below.

A copy or facsimile of this document shall have the same validity and effect as the original.

EXECUTED this _____ day of _____, 20__.

EMPLOYEE/PATIENT

DATE OF BIRTH:

SOCIAL SECURITY NUMBER: