AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this information is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

PATIENT NAME: SOCIAL SECURITY:

DATE OF BIRTH: CLAIM NUMBER:

I AUTHORIZE THE RELEASE OF MY INFORMATION TO:

Employers Preferred Insurance Company
Employers Assurance Company
PO Box 32036
Lakeland, FL 33802-2036
PHONE: (888) 682-6671
FAX: (800) 371-8204

REASON FOR DISCLOSURE: WORKERS COMPENSATION CLAIM

The patient or the patient's representative must read the following statements:
I, ______________________________________ understand that this authorization will remain effective for two (2) years, unless otherwise indicated here: _________________________________.

I understand that the information to be released may include diagnosis and/or treatment for alcohol and/or drug abuse, HIV test results, AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment, diagnoses and/or treatment related to other communicable diseases, and mental health records (including psychotherapy notes). This authorization also may include release of medical records for past and present, including but not limited to all charts, records, correspondence, physicians' orders, progress notes, nurses' notes, medication records, therapy notes, laboratory reports, x-ray reports, consents, operative notes, pathology reports, anesthesia reports, admission and discharge summaries and any other medical information.

I understand that I may revoke this authorization at any time by notifying EMPLOYERS in writing, but if I do, it will not have any effect on any actions that took place before EMPLOYERS received the revocation.

I acknowledge that I have read and understand the above and agree that this authorization was completed prior to my signature. I further agree that a copy of this authorization, whether a photocopy, facsimile, or otherwise, shall have equal standing as if it were an original.

Signature of Patient: ____________________________________Date:______________

If individual is unable to give authorization because of age, physical condition or otherwise, complete the following:
Individual is: ______ a minor, _____years of age, or ____.

State relationship to individual: ____________________________________

Signature of Representative/Legal Guardian: _____________________________Date:____________

Printed Name of Representative/Legal Guardian:_______________________________