

MEDICAL AUTHORIZATION/RELEASE

RE:

Please make available to Inspirien Insurance Company, or any of their agents, any and all information they request concerning any hospitalization and treatment including, but not limited to, my entire medical records, hospital records, reports, charts, x-rays, health screenings, etc., concerning any diagnosis and/or treatment of myself at any time whatsoever, for their use in the investigation of my workers' compensation claim. I recognize that the disclosure of such information may include disclosure to employees of Inspirien Insurance Company, their attorneys, agents, experts retained by or on behalf of the firm and other individuals and entities in the ordinary course of this investigation, and I consent to such disclosure. You are further authorized and requested to discuss with them any history or findings you have regarding me or my condition and I do hereby expressly waive any right I may have of privilege as your patient. This authorization, waiver of privilege and release is made voluntarily and is extended not only to the Inspirien Insurance Company, but also to any of their agents.

This authorization, waiver of privilege and release is made with knowledge of my rights pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. § 160 and 164, et seq., and I further waive any and all claims against Inspirien Insurance Company, their attorneys, agents, experts retained by or on behalf of Inspirien Insurance Company and other individuals and entities in the ordinary course of this investigation, as well as you, your employer, employees and agents, associated with the disclosure of the requested records and information as described herein.

This authorization, waiver of privilege and release expires upon the final disposition of this claim for workers' compensation benefits. I am aware that I may revoke this authorization, waiver of privilege and release at any time, in writing; however, such revocation does not have any effect upon disclosures made pursuant to this authorization, waiver of privilege and release, prior to such revocation.

Date:_____ Signature_____ Date of Birth_____

Witness: _____

GINA DISCLAIMER

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, *we are asking that you not provide any genetic information when responding to this request for medical information.* "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please list all the physicians who have rendered treatment to you within the last five years and any physicians that you have ever seen for similar complaints to your alleged on the job injury.

1. Name _____ Phone _____
Speciality _____
Address _____
2. Name _____ Phone _____
Speciality _____
Address _____
3. Name _____ Phone _____
Speciality _____
Address _____
4. Name _____ Phone _____
Speciality _____
Address _____
5. Name _____ Phone _____
Speciality _____
Address _____
6. Name _____ Phone _____
Speciality _____
Address _____
7. Name _____ Phone _____
Speciality _____
Address _____
8. Name _____ Phone _____
Speciality _____
Address _____

Please attach a separate sheet of paper if more space is needed.

Claimant's Name:

Claim Number:
