HIPAA COMPLIANT
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Please complete only the areas marked with an asterisk (*). Do not otherwise alter or amend this form.

NAME: _____ DOB: _____ SSN: _____

DISCLOSE TO: State Employee Injury Compensation Trust Fund (SEICTF), P.O. Box 1390, Montgomery, AL 36102-1390, including its agents and authorized representatives.

PURPOSE(S) OF DISCLOSURE: I am the claimant in an employee injury claim. SEICTF is the organization that is handling this claim. The purpose of the disclosure of these records is to allow SEICTF to evaluate my medical history and my damages and injuries in this case in the complete context of my medical history and to allow them a fair opportunity to use these records to determine any and all benefits for which I may be eligible as a result of this claim.

INFORMATION TO BE DISCLOSED: My intent is for you, the agency/healthcare provider listed below, to provide my complete record for all time periods to the above-named organization. Records to be provided may include but are not limited to: all records related to any worker's compensation claim by me, all payment records, all subrogation documents and letters, all documents, records, statements, first report of injury, physician reports and forms and all investigative notes and documents, all printouts on my health expense and payments and records, any documents showing whether your payments on my behalf completely resolve and/or satisfy the complete debt to a health care provider, all history and physical examinations; all progress note, physicians notes, and nurses notes; all lab reports; all x-ray reports, MRI reports, CT scans, Myelograms, EMG, and all other diagnostic procedure reports; all consultation reports and records; all emergency room records, all discharge reports; all after care plans; and all financial records. I specifically authorize the release of information relating to: all substance abuse records (including alcohol/drug abuse); all mental health, counseling, psychiatric, and psychological records.

RIGHT TO REVOKE: I understand that I may revoke this authorization by sending a signed, written notice to SEICTF and to the entity being authorized to disclose my health information pursuant to this document. However, I also understand that any revocation will be effective only to the extent that action has not already been taken in reliance of this authorization. **Unless specifically revoked in writing, this authorization shall remain in force until the settlement or final disposition of my employee injury claim**.

RECORDS TO BE DISCLOSED: ANY AND ALL RECORDS

I understand that SEICTF will not use these records for any other purposes than the purposes stated above. I understand that protected health information that is disclosed pursuant to this authorization may result in re-disclosure and may no longer be protected by federal law.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

*_____ *_____
Signature of patient or patient's personal representative Date

_____
Relationship to patient, if signed by personal representative

SEICTF USE ONLY

I hereby authorize _____ (name of agency/healthcare provider) to use and/or disclose my records/health information and the claims file notes and documents in accordance with the above information.