

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

The execution of this form does not authorize the release of information other than that specifically described below.

This Release is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

TO: All of my health care providers and facilities, regardless of date of care, including: (Print/type name of provider or facility)	PATIENT: Name: S.S. No.: Birth Date:	RELEASE TO: MSP Solutions, Inc. 999 18 th Street, Suite 3100 Denver, Colorado 80202
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I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

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| <input checked="" type="checkbox"/> Drug Abuse, if any | <input checked="" type="checkbox"/> Alcoholism or alcohol abuse, if any |
| <input checked="" type="checkbox"/> Sickle Cell Anemia, if any | <input checked="" type="checkbox"/> Psychological or psychiatric conditions, if any |
| | <input checked="" type="checkbox"/> Release of raw data concerning psychiatric conditions |

Information to be Disclosed <input checked="" type="checkbox"/> Copy of history & physical, discharge summary & operative reports <input checked="" type="checkbox"/> Copy of outpatient & E.R. admissions <input checked="" type="checkbox"/> Copy of complete hospital chart <input checked="" type="checkbox"/> Entire chart including office notes, letters And forms filled out by patient	<input checked="" type="checkbox"/> Release of health care records from other providers <input checked="" type="checkbox"/> Release of interpretations of X-Rays, MRIs, CT Scans <input checked="" type="checkbox"/> Other (specify):
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Dates Covered:

All admissions or care at this facility or by this doctor Limited to treatment dates & for conditions described below

Purpose(s) for which information is to be used: Evaluation and determination of my workers= compensation claim including compensability, relatedness, prior conditions, apportionment, temporary or permanent impairment or disability, work restrictions, and reasonableness and necessity of treatment.

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing to MSP Solutions at the address above, except to the extent that action has already been taken in reliance on it. In addition to the disclosure to the above-named company or firm, I consent to re-disclosure to the following entities, their agents and representatives: the workers= compensation carrier and/or third party administrator on the claim and the employer, the Division of Workers= Compensation, the Director=s Medical Examiners, Independent Medical Examiners including the Division of Workers= Compensation Medical Examiners, and the Office of Administrative Courts. Any authorized re-disclosure by MSP Solutions may lead to the information no longer being protected by HIPAA. All written communications to any physician or health care provider shall be simultaneously provided to me, or if represented, my attorney. I understand that my medical provider cannot condition treatment on my signing this authorization. Except as to communications with medical providers' clerical staff, related solely to billing or scheduling matters, this authorization does not authorize oral communications with any physician or health care provider without either (a) first providing reasonable notice and an opportunity for me and my attorney to be present, or (b) the consent of my attorney. Without my express revocation, this consent will expire one year from the date it is executed.

OTHER CONDITIONS - A copy of this authorization may be utilized with the same effectiveness as an original.

DATE	SIGNATURE OF PATIENT	PERSON AUTHORIZED TO SIGN FOR PATIENT _____
		Print or type name

COSTS: Reasonable cost has been defined as "not to exceed \$14.00 for the first 10 or fewer pages, \$0.50 per page for pages 11-40, and \$0.33 per page thereafter." See Rule XVIII Medical Fee Schedule E.7.b of Worker's Compensation Rules of Procedure.

Time: From receipt of this request, the Custodian of the record shall make a copy of the record available normally not to exceed five days excluding weekends and holidays. (Health Care Standards and 6CCR 1011-1.)

NOTE: Copies of released records to be supplied to opposing attorney or party by the organization, agency, or individual to whom this information is released within fifteen (15) days of receipt.