AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Social Security Number:_____
Address: _____Date of Birth: _____

I hereby request and authorize: _____
to release the following health information:

__Standard Chart Copy __ History and Physical __EKG
__Operative Report __ Discharge Summary __Pathology Report
__Other_____ _x_Entire Medical Record, dated_____

To the recipient: SDML WC Fund c/o
CLAIMS ASSOCIATES, INC/REHAB ASSOCIATES
PO Box 1898
Sioux Falls, SD 57101

For the purpose of: _____Workers Compensation Claim Investigation_____

I understand the above requested information may contain sensitive medical information, such as information regarding HIV/AIDS status, infectious diseases, pregnancy status, mental illness, and addictions, and I specifically agree to the release of this information.

This Authorization is effective until the information requested has been released. I know I may have the right to revoke this Authorization by contacting the releasing facility in writing.

I understand that I am under no obligation to sign this Authorization. I further understand that the recipient is not subject to the Health Insurance Portability and Accountability Act of 1996, and therefore the requested information may not be protected once it is released. I understand my right to inspect or obtain copies of this information under 45 CFR 164.524.

I hereby give the referenced medical provider(s) permission to disclose and discuss my medical information with the above noted recipients, and I release the referenced medical provider(s) from any liability or loss due to the release of any medical information. I understand that all information released will be handled confidentially and in accordance with all applicable laws.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Relationship to Patient if Representative Signature of Witness