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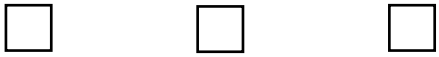
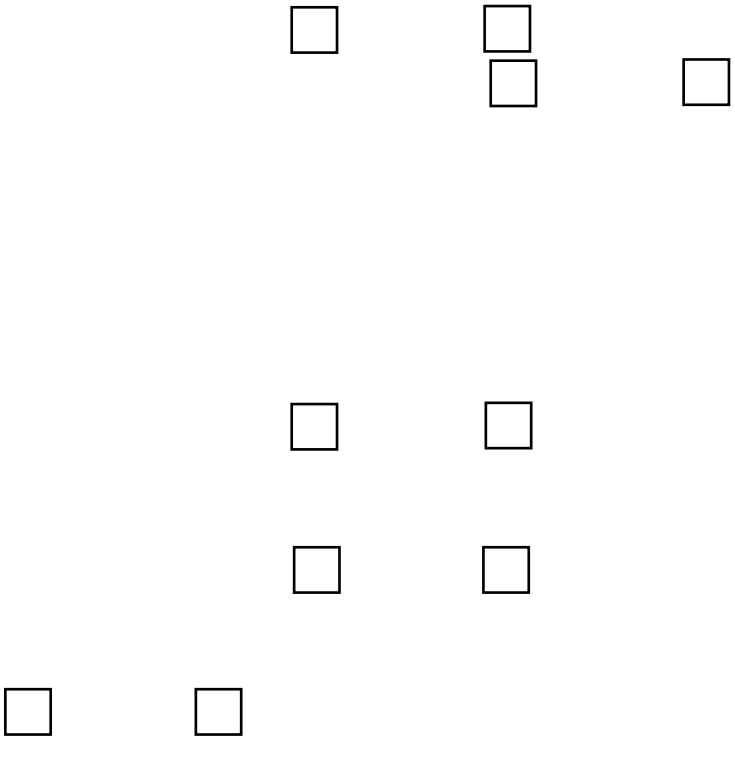
1st Employment

1 W Mountain Street	Fayetteville	AR	72701





AUTHORIZATION TO DISCHARGE HEALTH AND/OR MENTAL HEALTH INFORMATION FOR WORKERS' COMPENSATION INVESTIGATION AND CLAIM MANAGEMENT

Patient Name:_____

Health Record No: Unknown Date of Birth:_____ SSN: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:

Address:

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

▪**Entire Record, including records from any other medical or health care provider of any kind or source that may be contained within a portion of your files, even though not authored by your physician and/or facility.**

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organizations:

1st Employment Staffing, Inc.
P.O. Box 8712
Fayetteville, AR 72703

Zurich (Work Comp Carrier)
Gallagher Bassett (Claims Management)

For the purpose of: WORKERS' COMPENSATION CLAIM MANAGEMENT

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **This Authorization is valid until Workers' Compensation claim is resolved.**

7. A photostatic copy of this Authorization, or a carbon copy shall be construed as effective and valid as the original and that treatment, payment, or health care operations cannot be denied upon the granting or denial of this organization.

8. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

THIS REQUEST ALLOWS YOUR FACILITY TO RELEASE A COMPLETE COPY OF YOUR FILE AND NOT JUST SELECT PORTIONS.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

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