CORVEL

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release and disclosure of any and all information developed, oral and written, while under observation and treatment by you, your facility, or otherwise in your possession to CorVel Corporation and/or its representatives. This includes, but is not limited to records or reports concerning past, present or future physical, mental or emotional conditions and treatment thereof, history, findings, office and patient chart notes and files, examination and progress notes, physical evidence prepared by you, and future plans of care developed. This authorization will remain in effect until revoked by me in writing. I understand the information will be used for the administration and adjudication of my workers' compensation claim. A photocopy of this authorization will serve the same force and effect as the original.

Patient:
DOB:
Last four of SSN: XXX-XX- _____
Date of Accident:

_____
Patient or Legal Guardian Signature

_____
Print Name of Patient or Legal Guardian

_____
Date

**The Health Insurance Portability and Accessibility Act ("HIPAA") at 45 CFR, section 164.512 provides: "a covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault." **

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