

HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECORDS

I hereby authorize any medical facility or records custodian to allow Zenith Insurance Company and/or their attorneys or agents to review, inspect, and/or photocopy any and all of the following records:

- **Medical Records:** I authorize Zenith to obtain and the health care providers to release to Zenith or its designated representative copies of full and complete medical records, reports, diagnostic tests and test results or other documents related to the nature and extent of the treatment given or services and products provided and all health information relative to my physical condition, past, present or future, including but not limited to medical records, hospital records, physician orders, progress notes, nurses' notes, pathology reports, history/physical exams, patient allergies, discharge summaries, billing information, past/present medications and prescriptions, operation reports, diagnostic test reports, radiology reports and images, lab tests and results, consultation reports, EKG/Cardiology reports. **I specifically authorize Zenith to obtain and providers to release to Zenith or its designated representative reports concerning psychological or psychiatric conditions, treatment for alcohol or drug abuse, and treatment of communicable diseases including acquired immunity deficiency syndrome or human immunodeficiency virus.** I also authorize Zenith to obtain and health care provider or testing facilities to release to Zenith or its designated representative any blood/urine/hair/tissue samples for any testing or evaluations deemed necessary by Zenith for Workers' Compensation health care operation purposes.
- **Employment/Education Records:** I authorize my current/former employer, school, and/or correctional facility to release all personnel, attendance, and wage records.
- **Public:** I authorize the release of any and all police, ambulance, fire or other investigation reports, records and/or documents and papers of every kind or nature concerning the accident or other incident in which the undersigned was involved.
- **Insurance and Claim Records:** I authorize the release of any and all insurance claim files dealing with prior, present, or subsequent claims for injury or damages.

The health information authorized on this form will be used only for discovery regarding a workers' compensation claim.

DURATION: This authorization shall become effective immediately and shall remain in effect for ONE full year from date of signature.

REVOCAION: This authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt but will not be effective to the extent that the requester or others have acted in reliance upon this authorization. Written revocation is to be sent to Zenith Insurance Company and its agent.

HIPAA: I understand that by signing this authorization for release of records that medical providers will be releasing information subject to the HIPAA restriction. I specifically waive any rights or protections that I may have under the HIPAA regulation and request that medical providers release the requested information.

PROHIBITION OF USAGE, TRANSFER OR REDISCLOSURE OF INFORMATION: Except as required by state or federal laws, use of information released for other than the stated purpose or redisclosure or transfer of this information to any person or entity not named herein is prohibited. An additional written authorization must be obtained for any proposed new use of the information or its redisclosure or transfer of such information. Authorized information may be subject to redisclosure by the recipient and no longer protected by the privacy regulations. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this form.

**I understand that I have the right to receive a copy of this authorization.
A copy of this authorization shall be considered as valid as the original.**

Signature

Print Name

Date

If Signed by Other than Patient Indicate Relationship