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THE UNIVERSITY OF ALABAMA SYSTEM

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**MEDICAL RECORDS RELEASE
ALL SECTIONS MUST BE COMPLETE**

Name: _____
Street Address: _____
City: _____ State: _____
Date of Birth: _____ Social Security Number: _____
Medical Care Provider(s): _____
Insurance Provider: _____ Date of On-The-Job Injury: _____
Contract Number: _____ Group Number: _____

This is to authorize you to disclose/discuss all medical record information pertaining to my on-the-job injury to/with my employer, the University of Alabama in Huntsville. This information will be used to determine qualification for lost wage and/or medical expense benefits. You are authorized to accept a xerox copy of this authorization in lieu of the original.

1. The type of information to be used or disclosed is as follows:
 - All medical notes and/or reports in my file relating to this particular injury, as well as all notes and/or reports documenting a pre-existing injury that is the same in nature. (Including, but not limited to, medical history, physicals, operative notes, pathology reports, consultation reports, EKG reports, diagnostic studies, nurses' notes, progress notes, physician's orders, outpatient records, emergency department records, laboratory results, imaging results, and discharge summaries.)
 - A statement of account detailing all expenses incurred, payments made by my insurance provider, charge-off amounts, as well as any insurance co-payments I have made concerning this particular injury.
2. I understand that the information in my health record may include information relating to sexually transmitted diseases, 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/or drug abuse.
3. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to your Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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.
5. Unless otherwise revoked, this authorization will remain valid until I no longer require medical assistance for my injuries sustained in this incident or until my physician feels I have reached maximum medical improvement (MMI).
6. I understand that if I refuse to sign this Medical Records Release the University can not process my claim, therefore no lost wage and/or medical expense benefits will be provided.

SIGNATURE

DATE

SIGNATURE OF WITNESS

DATE

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