AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS PURSUANT TO 45 CFR 164.508 (HIPAA)

Patient Name: _____ **Social Security #: __ __ __ - __ __ - __ __ __ __**

Date of Birth: _____ / _____ / _____ Date of Injury/Onset of Illness: _____ / _____ / _____

TO: Any physician, surgeon, dentist, hospital, rehabilitation/convalescent/custodial facility, pharmacist, ambulance, nurse, other health care provider or insurance company.

I, _____, authorize you to disclose and release the following protected health information: **Any and all inpatient admissions, all ER visits, outpatient clinic notes, diagnostic testing, radiology films, consults, doctors orders, progress notes, nurses notes, laboratory testing, social service records, reports, correspondence, consultations, memoranda, treatment plans, admission records, discharge summaries, medical summaries, diagnoses, and/or any writing of any kind.**

Also, please disclose and release the following protected health care information (only if checked below):
o Drug and Alcohol Records o Communicable disease, HIV and AIDS Records
o Mental Health Records (not including Psychotherapy Notes)
This protected health information is disclosed for the following purposes: verifying, evaluating, negotiating and or other pertinent legal uses, with respect to the patient's insurance claim.

You are authorized to release the above records, or copies thereof, to any representative of Midwest Insurance Company, Midwest General Insurance Agency, MIC Risk Management at the following address: PO Box 13369, Springfield, IL 62791-3369.

I further authorize any health care provider to release any and all tests, reports, notes (excluding psychotherapy notes) and all other information concerning my medical and/or psychological conditions and/or treatment and to meet with, discuss and/or to correspond and report directly to Midwest Insurance Company, Midwest General Insurance Agency, MIC Risk Management or any representative(s) Midwest Insurance Company, Midwest General Insurance Agency, MIC Risk Management may designate to discuss my medical and/or psychological condition(s) or treatment.

I also authorize the provider of treatment to: 1) communicate directly with my employer, Midwest Insurance Company, Midwest General Insurance Agency, MIC Risk Management and/or its representatives on his/her own initiative, if necessary, concerning my medical and/or psychological condition(s) and/or treatment; and 2) consult with my employer, Midwest Insurance Company, Midwest General Insurance Agency, MIC Risk Management, and/or its representatives upon request provided that the responsibility for any charges for such consultation will lie solely with the requesting party of the consultation. I expressly waive any and all rights that I may have to be notified of these communications and to be present at consultations.

The purpose of such communications, correspondence, consultations and meetings is the same as set forth above with respect to my authorization for the disclosure of protected health information.

This authorization shall be in force and effect until the later of one year from the date signed or the date the claim has been legally concluded at which time this authorization expires.

I have the right to revoke this authorization, in writing, by sending written notification to you with copy to Midwest Insurance Company, Midwest General Insurance Agency, MIC Risk Management at the above address. I understand that a revocation is not effective to the extent that you have relied on my authorization to disclose protected health information.

I acknowledge that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Subpart E of the Regulations promulgated by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") relating to the privacy of individually identifiable health information.

Claims Center – Mailing
P.O. Box 13369 Springfield, IL 62791-3369
Phone: (800) 293-0616 – Fax: (217) 726-6943 – Email: claims@midins.com

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I further agree that a photocopy or facsimile copy of this Authorization shall be valid and effective just as the original.

I understand that I have the right to: 1) inspect or copy the individually identifiable health information to be disclosed; 2) refuse to sign this authorization; 3) receive a copy of this Authorization upon request.

_____

Signature of Patient or Personal Representative **Name of Patient or Personal Representative**

_____

Dated **Description of Personal Representative's Authority to Sign for Patient** (if applicable)

RH088 (05/2003)