TEXAS

AUTHORIZATION

To Disclose Health Information

I, _____ , authorize the use or disclosure of my individually identifiable health information, as described below, for purposes of administering my workers' compensation claim, which allegedly involves the following:

1. Any person or facility that has attended to, treated or examined me may disclose information.

2. The type and amount of information that may be used or disclosed is as follows:

   Any and all medical, psychological, psychiatric, chiropractic or therapeutic information, records and reports—including but not limited to narrative reports, billing records, office notes, diagnostic test reports, X-ray reports, prescriptions, correspondence, opinion letters, records of other health providers and work excuses—regardless of date.

   My healthcare providers are further hereby authorized to communicate directly with the individuals listed below (#3) regarding my medical condition, treatment, or any other issue relevant to my workers' compensation claim and/or work status.

   I understand that the disclosed information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), if relevant to my workers' compensation claim. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

3. This information may be disclosed to, discussed with, and used by individuals or organizations such as adjustors, carriers, employers, nurse case managers and attorneys for the purpose of administering my pending workers' compensation claim.

4. This authorization is valid until the final conclusion of my workers' compensation claim, unless otherwise revoked if I notify **Summit Claims Center, PO Box 2928, Lakeland, FL 33086-2928**, in writing. I understand that any revocation will not have any effect on any actions taken before they received the revocation.

5. I understand that I may inspect the disclosed information at any time. I further understand that any disclosed information may be redisclosed in accordance with the terms of this authorization and may no longer be protected by federal privacy regulations.

6. A photocopy of this authorization shall be valid and is to be accepted with the same effect as the original.

Date of accident _____

Printed name of claimant _____ Date _____

Signature of claimant _____ Social Security no. _____

Signature of witness _____ Date _____

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SUMMIT CLAIMS CENTER

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SOUTHEAST REGION *Georgia, Kentucky, North Carolina, South Carolina, Tennessee*
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