MACRO-PRO

AUTHORIZATION AND MEDICAL HISTORY FORMS

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Please call Macro-Pro Client Service if you require any assistance with these forms, have any questions, need additional copies or if you would like us to provide you with a different form.

(888) 554-0900

You can also download the forms at www.macropro.com

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MEDICAL HISTORY

Employee	**Employer**
Address	**Date Of Injury**
City, State, Zip Code	**Daytime Telephone Number**

Please list below all hospitals and doctors including medical doctors (MD), chiropractors (DC), osteopaths (DO), physical therapists, psychologists, psychiatrists, or any other medical care provider you have seen in the last 10 (ten) years.

Name, Address & Phone # Of Providers	Treatment Date(s)	Type Of Treatment

Signature **Date**

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EMPLOYMENT HISTORY

EMPLOYEE _____ **EMPLOYER** _____

ADDRESS _____ **DATE OF INJURY** _____

Please list below all past employers for the last *10 years.*

NAME, ADDRESS & PHONE NUMBERS OF EMPLOYER	APPROXAMITE DATE OF EMPLOYMENT

SIGNATURE _____ **DATE** _____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1.) I hereby authorize: _____
Name of Facility with Records/Disclosing Party

2.) To disclose to: _____
Name of Requesting Party (Requester): Insurance Carrier/Third Party Administrator/Self-Insured Employer/Attorney Firm
and/or their attorneys, through Macro-Pro, Inc., their agent, to review, inspect, and/or photocopy

Records and Information Pertaining To:

_____ _____
Name of Patient (List Other Names Used) Date of Birth

_____ _____
Address Daytime Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ or for one year from date of signature.
Date

REVOCATION: This authorization is also 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 those parties listed on line **1.)** and line **2.)** above.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY RECORDS TO BE DISCLOSED: Check box and initial/sign to specify which type of information is to be disclosed.

☐ **MEDICAL INFORMATION** _____ **Initial**

☐ **MEDICAL BILLING** _____ **Initial**

☐ **X-RAYS AND FILMS** _____ **Initial**

☐ **PSYCHIATRIC INFORMATION**

_____ _____
Signature **Date**

☐ **DRUG/ALCOHOL INFORMATION**

_____ _____
Signature **Date**

☐ **HIV/AIDS TESTING, DIAGNOSIS, & TREATMENT**

_____ _____
Signature **Date**

OTHER HEALTH INFORMATION TO BE DISCLOSED:

_____

_____

_____

The requester may use the health information authorized on this form for the following purposes only:

_____

_____

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

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HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECORDS

1.) I hereby authorize: _____
Name of Facility with Records/Disclosing Party

2.) To disclose to: _____
Name of Requesting Party (Requester): Insurance Carrier/Third Party Administrator/Self-Insured Employer/Attorney Firm

and/or their attorneys, through **Macro-Pro their agent**, to review, inspect, and/or photocopy **any and all of the following from any and all dates** which are in your possession or control:

- **Medical records**, to include but not limited to: Medical files, reports, charts, graphs, notes, tests, x-rays, MRI's, billings and laboratory reports.
- **Employment and/or Union records** to include but not limited to: Personnel file, medical and insurance, pension benefit records and wage records.
- **EDD Disability and Unemployment Records**
- **Scholastic Records**
- **Insurance and Claim Records**
- **Police, Prison or Probation Records**

SENSITIVE INFORMATION: By **marking the boxes** below, I hereby authorize the release of information concerning:

- ☐ **HIV and/or AIDS Information**
- ☐ **Psychiatric and Mental Health Information**
- ☐ **Sexually Transmitted Disease Information**
- ☐ **Alcohol and/or Drug Information**
- ☐ **Genetic Records**

The health information authorized on this form will be used for the following purposes only**:** **Discovery for a Liability or Workers' Compensation claim.**

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

REVOCATION: 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 those parties listed on line 1.) and line 2.) above.**

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use and disclosure is specifically required or permitted by law.

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