EQUIAN
P.O. Box 36380
Louisville, KY 40233
FAX: (502) 214-1291

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) UNDER HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) and FOR RELEASE OF ALL OTHER ACCIDENT RELATED INFORMATION

1. The undersigned patient named below, hereby executes this authorization in compliance with the federal Health Insurance Portability and Accountability Act. HIPAA, 45 CFR 164.104.

2. This authorization is directed to the following:

   (1) healthcare provider, (including its agents, employees and associates); and
   (2) OTHER insurance carriers; and
   (3) Any other parties with relevant information regarding the accident.

3. The above named persons/entities are requested to release the protected health information (PHI) *and all other information related to the accident of <date> relating to <patient name> that is described below*, to Equian, 9390 Bunsen Parkway, Louisville, KY 40220.

4. *The protected health information released herein is specifically as follows:*

All medical information of any nature, from any source whatsoever, which is maintained by you in your records regarding the referenced patient and which is requested by Equian. If you are a physician or out-patient clinic, you are authorized to send your entire chart, upon request of Equian, including not only the records dictated or written by you, but also insurance records, handwritten notes, telephone memoranda, outside records, correspondence, or any other tangible item maintained in my chart.

The records include but are not limited to the following items:

____Most Recent History and Physical _____All From _____ to _____

____Most Recent Discharge Summary _____All From _____ to _____

____Initial Patient Paperwork/Questionnaires _____All From _____ to _____

____Office Notes and Reports _____All From _____ to _____

____Physical Therapy Records and Notes _____All From _____ to _____

____Laboratory Reports and Results _____All From _____ to _____

____X-ray and Imaging Reports _____All From _____ to _____

____Consultation Reports by any other Physicians _____All From _____ to _____

____Entire Record and/or Chart

____Final Narrative Reports & Impairment Ratings

____Itemized Bill for Services Rendered _____Total Charges _____Balance

Other PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

5. *Other information shall include:*

All information regarding the accident including accident reports, payment logs including PIP and med pay payment logs, and _____.

REQUIRED DISCLOSURES - 45 CFR 164.508(c)

A. This protected health information is to be used for the following purpose: A civil legal claim or proceeding against any party, other than the patient, responsible for the injuries related to the treatment.

B. This authorization may be revoked by a signed and properly dated written revocation, delivered to the healthcare provider or other entity named above, provided that this release cannot be revoked as to protected health information that had been previously released in reliance on this document.

C. The undersigned acknowledges that a refusal to sign this form will not result in a denial of health care by the hospital or any other health care provider and that this release has not been coerced by a covered entity or any of its business associates.

D. The undersigned acknowledges that once the PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, insurance companies, and even may become public record if filed with a court of law.

E. This authorization will expire twelve (12) months after the date executed, unless earlier revoked in writing. A copy of this document shall be treated as an original.

F. The undersigned acknowledges that he/she has a right to retain or receive a copy of this authorization. If you are not making a copy of this authorization form for your records and want to receive a copy from Equian, then please initial here: _____.

PLEASE RELEASE RECORDS TO COPY SERVICE:

RECORDS DEPOSITION SERVICE, INC.

P.O. BOX 5054, SOUTHFIELD, MI 48086-5054

Signed: _____

Patient Name: _____

DOB: _____

SSN#: _____

Dated: _____