Authorization for Release of Information

I, ________________, hereby authorize the **Cincinnati Insurance Companies**, P.O. Box 145496, Cincinnati, Ohio 45250-5496 to furnish to _**Records Deposition Service Inc.** and/or its authorized representative any and all information, medical bills and/or health insurance explanations/statement and records or copies of records, including x-rays, psychotherapy notes and any other notes or correspondence relating to the history, diagnosis, treatment, prognosis and/or prescription information in its possession concerning me, including, without limitation, all information relating to mental, psychiatric, psychological or emotional illness or conditions, HIV testing or treatment of AIDS or AIDS-related conditions, alcoholism and drug use or abuse or services rendered to the individual named below in connection with any condition, disease or ailment for which treatment, consultation or hospitalization is now being or has heretofore been given.

I understand that:

1. The information obtained pursuant to this authorization may be re-disclosed by the individual or entity listed in the first paragraph.
2. Revocation of this authorization should be sent directly to the individual listed in the first paragraph. Revocation will not affect information that has already been collected, used or disclosed in reliance on this authorization.
3. Information disclosed pursuant to this authorization may no longer be subject to state or federal privacy regulations and laws.
4. This authorization will be valid from the date signed for a period of two years.
5. Any request that I have made to my medical providers to restrict information disclosed does not apply to this authorization. I instruct the Cincinnati Insurance Companies, listed in the first paragraph of this authorization to release and disclose my entire medical record without restriction.
6. I agree to protect, defend, and indemnify The Cincinnati Insurance Company, its subsidiaries, their respective successors, assigns, directors, officers, employees, agents, and affiliates from and against all claims, demands, actions, suits, damages, liabilities, losses, settlements, judgments, costs, and expenses that may result from the release of my protected health information.
7. A photographic copy of this authorization shall be as valid as the original.

Signed on: ____

Month Day Year

______________________________	______________________________
Name of Patient (please print)	Signature of Patient (if signing as personal representative, specify relationship to Patient)
______________________________	______________________________
Witness	Previous Legal Name (If applicable)

Date of Birth__________________________

SSN___________________________