THE BEST REMEDY FOR WORKERS' COMPENSATION™

AUTHORIZATION TO DISCLOSE NON-PUBLIC PERSONAL HEALTH INFORMATION AND WAIVER OF PRIVILEGE

TO: All Medical Providers

Patient Name: ____

Claim Number: ____________ Birth Date : ______________ SSN : ______________________

1. I, ______________________________, hereby authorize the above named health care provider to give to, release, and permit copies to be made of all health care records that are in your possession.

2. The health care records should be disclosed to any authorized representative of Argent. Argent is the insurer for the employer and acts as its agent for insurance purposes.

3. The purpose of the disclosure of these records is to aid Argent's evaluation of my claim.

4. Argent may re-disclose my records to others retained by Argent to assist in the evaluation of my claim, and thus, my records may no longer be private.

5. The type of information to be disclosed may include, but is not limited to, x-rays, x-ray reports, summaries, reports, narratives, test results, notes and any other health care records from all in-patient and out-patient visits at your institution or facility.

6. This authorization also permits release of all information relating to treatment for:
   a. drug and/or alcohol abuse;
   b. any mental disease, defect, or psychological/psychiatric condition;
   c. any communicable disease, AIDS, or AIDS-related disease.

7. I further authorize the provider to release any information in their possession and to meet with, discuss with, and/or to correspond and report directly to Argent or any representative it may designate to discuss my medical and/or psychological condition(s) and/or treatment. These authorized communications may be initiated by the treatment provider. I also waive the right that I may have to be notified of these communications and to be present at consultations.

8. I understand that executing this authorization is a waiver of my privilege of physician-patient confidentiality, and I freely and voluntarily waive that privilege.

9. The above-named health care provider may not condition treatment, payment, enrollment or eligibility of benefits on obtaining your authorization.

10. A photocopy or facsimile of this authorization shall be valid and effective just as the original.

11. I understand that I may revoke this authorization, in writing to the records department of the above named health care provider, at any time, except where information has already been released as a result of this authorization.

12. Unless revoked, this authorization shall remain in effect for the period of one year beyond the date of patient's signature, or until my claim is closed, whichever is later. Records may be disclosed whether dated before or after the date of this authorization.

13. I understand that I or my authorized representative is entitled to receive a copy of the completed authorization form.

Signature of Patient/Guardian ________________________ Date: __________
Social Security Number: ____________________________ Birth Date: ______
Witness Signature: ________________________________ Date: __________

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