ARGENT®
A DIVISION OF WEST BEND

THE BEST REMEDY FOR WORKERS' COMPENSATION™

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

TO:

Patient Name:
Claim Number:
Birth Date:
Social Security Number:

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.

The health care records should be disclosed to any authorized representative of Argent, a division of West Bend Mutual Insurance Company. Argent, a division of West Bend Mutual Insurance Company, is the insurer for the employer and acts as its agent for insurance purposes.

The purpose of the disclosure of these records is to aid Argent's, a division of West Bend Mutual Insurance Company, evaluation of my claim.

Argent, a division of West Bend Mutual Insurance Company, may re-disclose my records to others retained by Argent, a division of West Bend Mutual Insurance Company, to assist in the evaluation of my claim. Re disclosure of this protected health information will no longer be protected under any federal or state privacy law.

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

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.

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

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

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

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.

Unless revoked, this authorization shall remain in affect 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.

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

_____ _____

Signature of Patient/Claimant Date

_____ _____

Signature of Patient/Claimant Date

WR-0210(7-18)