AdminSure

3380 Shelby Street
Ontario, California 91764

Telephone (909) 861-0816
Fax (909) 860-3995

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION – HIPAA

I hereby authorize use of disclosure of the named individual's health information as described below.

Patient Name _____ Birth Date _____ Social Security Number _____

City of Palm Springs
Employer Name

RELEASE TO:

AdminSure, Inc.

3380 Shelby Street

Ontario, CA 91764

Phone: (909) 861-0816 **Fax: (909) 860-3995**

- [x] any and all records
- [ ] physician reports only
- [ ] discharge summary
- [ ] insurance of claim records
- [ ] other medical records or health information here specified _____
- [ ] MRI, X-rays, film
- [ ] history & physical examinations
- [ ] laboratory tests
- [ ] employment, payroll, educational or job training
- [ ] radiology reports
- [ ] consultation and progress notes
- [ ] police, arrest, prison, or probation records

Sensitive Information: I understand that this may include information relating to (Check to Authorize Release)

- [ ] acquired immune deficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
- [ ] behavioral health services, psychiatric care, mental health treatment
- [ ] diagnosis/treatment for alcohol and/or drug abuse
- [ ] sexually transmitted disease
- [ ] information for research purposes

Services provided on (dates): _____

Purpose of this request: ✓ Discovery for Worker's Compensation Claim ☐ Other _____

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure, and that the recipient may not be governed by the federal privacy and confidentiality legislation.
Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.
Expiration: Unless otherwise cancelled, I understand that this authorization will expire on this date _____
Other Rights: I understand that authorizing the disclosure of this information is voluntary.
I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524
***A PHOTOCOPY OF THIS SIGNED AUTHORIZATION WILL BE DEEMED AS EFFECTIVE AS THE ORIGINAL**

_____ _____
Signature of Patient or Personal Representative Date

_____
If signed by Representative, Relationship to Patient

Please list the names, addresses, telephone numbers, and patient identification numbers of all physicians/dentists/psychologists seen in the past.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list the date of injury, body part injured, employer at the time of injury, work restrictions, if any, and percentage of permanent disability awarded.

1. _____
2. _____
3. _____
4. _____
5. _____