Authorization to Use or Disclose Confidential Information

Name _____ Date of Birth: _____

Insurance Claim #: _____ Date of Injury: _____

I authorize the use or disclosure of the above named individual's health information as described below. The following individual(s) or entities to *make* the disclosure:

and any other healthcare provider, hospital, clinic, and/or physician treating me for this injury.

The information identified above may be *used by or disclosed to* Representatives of Starr & Associates, Inc.

The type of information to be used or disclosed is as follows: Check One:

- ❑ Option One: All correspondence records, and other information regarding the patient's physical health, treatment, and evaluation by any physician, chiropractor, osteopath, dentist, physical or occupational therapist, nurse, hospital, or any other health care provider.

- ❑ Option Two: All correspondence records, and other information regarding the employee's or patient's physical and mental health, drug and alcohol abuse, HIV and AIDS tests, treatment, and evaluation by any physician, psychologist, psychiatrist, chiropractor, osteopath, dentist, physical or occupational therapist, nurse, hospital, or any other health care provider.

Patient (or Person Authorized to Sign for Patient) – for Option Two:

This information for which I am authorizing disclosure will be used for the purpose of management of a worker's compensation, auto no fault, or disability claim.

This authorization will expire one (1) year from the date on which it was signed.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department (of Starr & Associates, Inc. at 601 3 Mile Rd NW Ste A, Grand Rapids, MI 59544). I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to medical information pertaining to my claim (refer to HIPAA Sec 164.512(a)(l)).

I understand that I have the right to receive a copy of the disclosed records and information, upon written request to the health care provider. The person to whom the information is disclosed may re-disclose the information without authorization or knowledge from Starr & Associates, Inc.

I understand that if the organization authorized to receive the information is not a health plan or health care provider; the disclosed information may no longer be protected by federal privacy regulations.

I understand that authorizing the use or disclosure of the information identified above is voluntary. I understand that by authorizing the use and disclosure of this information there will be no conditions placed upon my health care or payment of my health care by Starr & Associates, Inc.

I agree that a photocopy or facsimile of this Authorization shall be valid and effective just as the original, and that I will receive a copy of this form after I have signed it.

Signature of Patient (or Person Authorized to Sign for Patient)	Date: