Claim #:
Caption:

Authorization to Disclose Health Information

Patient Name: ______________________________
Date of Birth: ______________________________ Social Security Number: ______________________

1. I authorize the use or disclosure of the above-named individual's health information as described below.

2. The individuals or organizations listed on page two are authorized to make disclosure.

3. The type and amount of information to be used or disclosed is as follows:
   medical records, office notes, hospital records, pharmaceutical records, x-ray films, MRI films, CAT scans, other radiological films and medical bills concerning my medical treatment arising out of or prior to the date of accident.

Your signature must appear on the line next to the below listed items for the following types of health information to be released. Your initials and signature must also appear at the bottom of both pages respectively.

HIV/AIDS related information and/or records ____________________________________
Mental Health information and/or records ____________________________________
Drug/Alcohol diagnosis and treatment information ____________________________________
Pregnancy/Family Planning related information ____________________________________
Physical/Sexual Abuse related information and/or records ____________________________________
Sexually Transmitted Disease related information and/or records ____________________________________

4. This information may be disclosed to and used by the following individual or organization:

   Cove Risk Services, LLC
   P.O. Box 859222-9222
   Braintree, MA 02185
   1-800-790-8877 or 1-781-843-0005
   (FAX) 1-800-382-8891 OR 781-843-0565

   for the purpose of a legal workers' compensation claim.

5. 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 and present my written revocation to the person or entity I authorized to release my information. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the closure of my pending Workers' Compensation Claim or one year from the date signed, whichever is later.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.

7. I authorize Cove Risk Services, LLC, its agents or assigns to communicate or correspond with my treating doctors for purposes of medical history, diagnosis, treatment, degree of disability, ability to return to work or permanency.

8. A photocopy of this authorization shall be considered as effective and valid as the original.

Patient Initials: __________
Date: ___________________

Claim #:
Caption:

Authorization to Disclose Health Information (continued)

Name and Address of Medical Provider: ______________________________
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Name and Address of Medical Provider: ______________________________
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Name and Address of Medical Provider: ______________________________
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Name and Address of Medical Provider: ______________________________
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Name and Address of Medical Provider: ______________________________
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Name and Address of Medical Provider: ______________________________
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Name and Address of Medical Provider: ______________________________
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Name and Address of Medical Provider: ______________________________
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Signature of Patient: ______________________________
Date: ____________________