Claim Number:
Date of Injury:

Authorization to Disclose Health Information

Patient Name: DOB:

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

2. The individuals or organization listed below are authorized to make disclosure.

3. The type and amount of information to be used is as follows: **Medical records, office notes, 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 injury.**

4. This information may be disclosed to and used by the following individual or organization: Cove Risk Services, LLC PO Box 8599222-9222 Braintree, MA 02185 for the purposes of a legal workers' compensation claim.

5. I understand 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 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.

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

Name and Address of Medical Provider: _____

_____

_____

Name and Address of Medical Provider: _____

_____

_____

Name and Address of Medical Provider: _____

_____

_____

Signature of Patient _____

Date: _____

P.O. Box 859222-9222
Braintree, MA 02185
800-790-8877 . 800-382-8891 Fax
www.coverisk.com