Please print and mail to: NPFBA, PO Box 31, Martell, CA 95654

AUTHORIZATION FOR RELEASE OF INFORMATION – HIPAA COMPLIANT – PART 1

Records Subject:

Individual: ____

AKA: ____

Social Security Number: ______________________

Date of Birth: ______________________

Service Provider:

Requesting Records from:

____

Requested By:

Law Firm/Insurance Company requesting records: National Peace Officers and Firefighters Benefit Association (NPFBA)

The Service Provider is directed to make available for copying all records pertaining to the Individual. Including, but not limited to, any and all files, photographs, video and/or audio tapes and/or records for all injuries or conditions in the Service Provider's possession or under the Service Provider's control that is held for any purpose.

Nothing shall be removed, deleted, altered or withheld.

If additional items are to be disclosed or NOT disclosed by Service Provider, you must check ALL appropriate boxes.

Release Records	Do NOT Release Records	
❑	❑	All medical records during the care and treatment, hospitalizations, evaluations, testing, examination, office visits, emergency room, or lab testing. Including, but not limited to, nurse's notes, operative and pathology reports, emergency room records, surgery records, physical therapy records, in-patient and outpatient charts, MD progress notes, consults, MD orders, discharge summary, MD orders, prescriptions, EKG, and EMG, EEG.

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Authorization For Release Of Information – Hipaa Compliant – Part 2

Release Records	Do NOT Release Records	
❑	❑	All Original X-ray films, MRI films, CT Scans, and film reports.
❑	❑	All psychiatric, drug and/or alcohol treatment, evaluation, treatment, abuse testing, counseling, rehabilitation records. **Initial Here** _______
❑	❑	All mental health information consisting of, but not limited to, all notes, records and reports of psychotherapy diagnosis, evaluation and treatment. **Initial Here** _______
❑	❑	All employment records, including, but not limited to, payroll records, absenteeism or time off, benefits, applications, and claim records, applications for employment, work absentee records, time cards, incident reports, W-2s, 1099s, pre-employment exam records and employee progress records.
❑	❑	All insurance records, including correspondence, payments, photographs, underwriting and claim records. Including, but not limited to, copies of policies involved, payments made there under, medical records submitted by the company or other physicians. Any and all documents, including, but not limited to, Declarations of Coverage, which evidence compliance with California Financial Responsibility Laws at the time of the accident.
❑	❑	All HIV test results or any related AIDS virus information. **Initial Here** _______

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Authorization For Release Of Information – Hipaa Compliant – Part 3

At the request of the Individual this information will be used for the purpose of aiding the Individual and his or her attorney in establishing the liability, nature and extent of a claim for injuries and disabilities and to establish benefits, expenses, compensation and damages. The information provided may be disclosed by NPFBA to other parties and/or treating/evaluating physicians. This Authorization does not permit the Service Provider to allow the copying of records by any other copy service or business associate as defined by the Health Insurance Portability and Accountability Act (HIPAA). This Authorization does not permit disclosure of any information to any person, entity, provider or insurance company other than the copying of records by a representative of NPFBA. Any and all Authorizations signed before this Authorization are revoked.

Individual designates and authorizes NPFBA as his/her representative to pursue any and all legal remedies necessary to compel the production of records from the Provider.

A copy of this Authorization is as valid as the original; the original is not required to be shown. The Individual has the right to revoke this Authorization at any time by giving the Provider written notice of revocation of this Authorization. A copy of this signed Authorization will be given to the Individual after it has been signed. **The Individual has the right to refuse to sign this Authorization.**

This authorization shall expire three years from the date of execution below unless a different date is specified here _______________.

____ _______________________

Individual's Signature or Representative Date

____ _______________________

If signed by other than Individual indicate relationship (Parent, Guardian or Conservator) Date

This authorization was created in 14-point type in accordance with California Legislature Assembly Bill 715.