

AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

Patient Name: _____ SS# _____
Claim Number _____

To any physician, dentist, hospital, health care practitioner, military authority, education authority, employer or insurance carrier: The requested information is needed to accurately evaluate, adjust and pay the patient's insurance claim.

THE UNDERSIGNED authorizes and requests the above-named provider to disclose and release my medical information, including my protected health information, to Bituminous Casualty Corporation, its agents, servants, attorneys and/or employees.

The information to be disclosed shall consist of true, correct and complete copies of all medical records of any kind, including, but not limited to: medical reports, consultation reports, doctors' notes, nurses' notes, X-rays, X-ray readings, laboratory records and/or reports, all tests and reports thereof, correspondence, drug or alcohol records, health information related to psychological or psychiatric conditions, including psychotherapy notes, HIV test results and any AIDS or AIDS-related diagnosis.

The purpose of this Authorization is to provide my medical records for purposes of investigation, discovery, depositions, hearings, trials and other proceedings in connection with a claim I have made. I understand that information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but such information will not be redisclosed by the recipient except to parties authorized to participate in evaluation of information related to my claim or as required by law.

I understand that the provider's treatment services to me are not contingent upon my desire to provide or withhold consent to release information.

I understand that I may revoke this Authorization at any time by providing written notice to the above-mentioned provider. I understand that revocation will not apply to any actions taken before the revocation is received. Unless otherwise revoked, this Authorization will expire one year from the date signed. A photocopy or faxed copy of this Authorization is to be given the same force and effect as the original.

Date: _____ (Signature)

Date of Birth _____ (Address)