HIPAA AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, authorize the health care providers identified in paragraph 2 below to disclose protected health information ("PHI") about me as described in this Authorization:

1. The information to be disclosed is all medical documentation, including but not limited to medical history, consultation, prescription, or treatment, copies of hospital records, radiology reports, test results, x-ray, MRI, CT Scan and myelogram films or plates, clinic notes, including diagnostic and prognosis related to my work- related injury of _____ ("work injury").

2. _____ and any other health care provider or facility who treats me for my work injury ("Identified Health Care Providers") may disclose the above-described information to CorVel Corporation and/or Vocational Case Manager or Medical Case Manager employed by CorVel Corporation.

3. This disclosure is made for the following purposes: As requested by the individual for workers' compensation purposes.

4. I understand that the Identified Health Care Providers are not conditioning my treatment, payment, enrollment, or eligibility for benefits on whether I agree to sign this authorization.

5. I understand that the information disclosed pursuant to this authorization may no longer be protected by the federal health privacy rule and may be subject to re-disclosure by the recipient.

6. I understand that I have the right to revoke this authorization in writing at any time by sending a letter to the Privacy Officer of the Identified Health Care Provider and that the effective date of my revocation will be the date the Privacy Officer receives it. I further understand that any revocation will be effective only to the extent that Identified Health Care Providers has not already taken action in reliance on this authorization.

7. This Authorization shall expire twelve months from the date of signature.

_____
Name of Employer (School)

_____
Printed Name (Employee)

_____ _____
Signature (Employee) Date

_____
Witness

_____ _____
Relationship to Employee (supervisor, Principal etc) Date