



AUTHORIZATION FOR MEDICAL INFORMATION

Patient Name: Rodney Lester Larson

Social Security #: 478-52-1117

Date of Birth: September 27, 1944

Date of Injury: January 21, 2015

I GIVE PERMISSION TO MY PHYSICIAN OR OTHER HEALTH CARE PROVIDERS, HOSPITALS OR CLINICS TO RELEASE MY MEDICAL RECORDS RELATING TO THIS INJURY/ILLNESS TO ALLEGIS GROUP, IT'S DIVISIONS EASI, AEROTEK, TEKSYSTEMS, OR ITS AGENTS. THIS INCLUDES, BUT NOT LIMITED TO HISTORY, FINDINGS, OFFICE AND PATIENT CHARTS, EXAMINATION AND PROGRESS NOTES, X-RAYS AND DIAGNOSTIC TEST RESULTS. I UNDERSTAND THAT THIS INFORMATION WILL BE USED TO ASSIST MY EMPLOYER IN EVALUATING MY INJURY/ILLNESS AND MY WORK STATUS.

DISCLOSURE OF MEDICAL INFORMATION PURSUANT TO THIS AUTHORIZATION IS NOT PROHIBITED UNDER THE HEALTH INSURANCE PORTABILITY AND ACCESSIBILITY ACT (HIPAA)

THE HEALTH INSURANCE PORTABILITY AND ACCESSIBILITY ACT (HIPAA) AT 45 CFR SECT. 164.512 PROVIDES: "A COVERED ENTITY MAY DISCLOSE PROTECTED HEALTH INFORMATION AS AUTHORIZED BY AND TO THE EXTENT NECESSARY TO COMPLY WITH LAWS RELATING TO WORKERS' COMPENSATION OR OTHER SIMILAR PROGRAMS, ESTABLISHED BY LAW, THAT PROVIDE BENEFITS FOR WORK-RELATED INJURIES OR ILLNESS WITHOUT REGARD TO FAULT"

Signed: _____

(Patient)

Date: _____

PROVIDER: PLEASE MAIL TO:

RISK MANAGEMNT DEPARTMENT
7301 Parkway Drive
Hanover, MD 21076
Phone: (800) 336-7091