HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize _____**[name of physician, hospital or health care provider]** to furnish to Freeman Administrative Services, Inc., its employees, agents, and authorized representatives (hereafter individually and collectively referred to as "FAS"), any and all of my medical records and related information pertaining to my care and treatment as the result of my injury, illness, and/or claim for benefits. The medical records and related information includes, but is not limited to, medical histories, reports, charts, notes, letters, x-rays, films, MRIs, CT scans and reports, itemized bills with treatment codes, insurance and claim records, correspondence, payments, consultations, examinations, prescriptions, diagnosis, tests, and treatments.

I understand that this information is being obtained to assist in the evaluation of my claim for benefits.

I understand that this information may be used to adjust, describe, or report matters about my care and treatment to persons entitled to receive this information.

I understand that I may revoke this authorization at any time by sending written notice to FAS except to the extent that FAS and _____**[name of physician, hospital or health care provider]** have taken action in reliance on this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to further disclosure and no longer protected by the federal health information privacy regulations. However, FAS will take precautions to maintain the confidentiality of the information disclosed pursuant to this authorization. I hereby release FAS from any liability or loss due to the release of any such information.

This authorization expires one year from the date of this authorization or the date that my claim is finally closed, whichever occurs first.

Nothing contained herein shall affect the treatment, payment, enrollment, or eligibility for benefits in accordance with all applicable laws.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction. A photocopy of this authorization shall have the same validity as the original.

_____ _____

Signed Date

Name: _____

Address: _____

Telephone: _____ SSN: _____

_____Relationship or Authority of Personal Representative (if applicable)