MACRO-PRO

HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECORDS

1.) I hereby authorize: _____
Name of Facility with Records/Disclosing Party

2.) To disclose to: LWP Claims Solutions
Name of Requesting Party (Requester): Insurance Carrier/Third Party Administrator/Self-Insured Employer/Attorney Firm

and/or their attorneys, through **Macro-Pro their agent**, to review, inspect, and/or photocopy **any and all of the following from any and all dates** which are in your possession or control:

_____ ____/____/____
Name of Patient (List Other Names Used) Date of Birth

- **Medical records**, to include but not limited to: Medical files, reports, charts, graphs, notes, tests, x-rays, MRI's, billings and laboratory reports.
- **Employment and/or Union records** to include but not limited to: Personnel file, medical and insurance, pension benefit records and wage records.
- **EDD Disability and Unemployment Records**
- **Police, Prison or Probation Records**
- **Scholastic Records**
- **Insurance and Claim Records**

SENSITIVE INFORMATION: By initialing below, I hereby authorize the release of information concerning:

____ **Psychiatric and Mental Health Information** Initial

____ **HIV and/or AIDS Information** Initial

____ **Alcohol and/or Drug Information** Initial

____ **Genetic Records** Initial

____ **Sexually Transmitted Disease Information** Initial

The health information authorized on this form will be used for the following purposes only: **Discovery for a Liability or Workers' Compensation claim.**

DURATION: This authorization shall become effective immediately and shall remain in effect until_____or for ONE full year from date of signature.

REVOCATION: This authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt but will not be effective to the extent that the requester or others have acted in reliance upon this authorization. **Written revocation is to be sent to those parties listed on line 1.) and line 2.) above.**

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use and disclosure is specifically required or permitted by law.

I understand that I have the right to receive a copy of this authorization.
A copy of this authorization shall be considered as valid as the original.

_____ _____ _____
Signature Print Name Date

_____
If Signed by Other than Patient, Indicate Relationship

MACRO-PRO

MEDICAL HISTORY

Employee	**Employer**
Address	**Date Of Injury**
City, State, Zip Code	**Daytime Telephone Number**

Please list below all hospitals and doctors including medical doctors (MD), chiropractors (DC), osteopaths (DO), physical therapists, psychologists, psychiatrists, or any other medical care provider you have seen in the last 10 (ten) years.

Name, Address & Phone # of Providers	Treatment Date(s)	Type of Treatment

Signature **Date**

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

MR #: _____

Name: _____

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

IMPRINT AREA

I understand that Kaiser Permanente will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

I hereby authorize:

_____
Name of Disclosing Party

_____
Address

_____
City State ZIP

To disclose to:

_____
Name of Recipient c/o Agent:
Macro-Pro, Inc. P.O. Box 93010

Address
Long Beach CA 90809-3010

City State ZIP

If requesting your own records for yourself, specify facilities: _____

Records and information pertaining to:

_____ _____ _____
Name of Member/Patient (List Other Names Used) Medical Record Number Date of Birth

_____ _____
Address Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (Date).

REVOCATION: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY RECORDS: Check the box, initial and/or sign to specify which type of information is to be disclosed.

- ☐ **MEDICAL INFORMATION** _____ (Initial)
- ☐ **PSYCHIATRIC INFORMATION**
- ☐ **DRUG/ALCOHOL INFORMATION**
- ☐ **RESULTS OF AN HIV TEST**
- ☐ **GENETIC RECORDS**

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

Specify the records to be disclosed: _____

The recipient may use the health information authorized on this form for the following purposes:

_____

A copy of this authorization is as valid as the original.
Member/Patient has a right to a copy of this authorization.

_____ _____ _____
Date Signature If Signed by Other than Member/Patient, Indicate Relationship