AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND REPORTS INCLUDING PSYCHOTHERAPY NOTES

Name: _____

Date of Birth: _____

Social Security Number: _____

I hereby authorize all health care providers, hospitals, clinics and institutions, medical facilities, mental health clinics, mental health hospitals, pharmacies, to release all existing medical records and information regarding the above referenced patient's medical care, treatment, physical/mental condition and medical expenses revealed by your observation or treatment of past, present and future to:
MPE Workers' Compensation Services, Inc., P.O. Box 22729, Jackson, MS 39225

I understand that this authorization includes information regarding the diagnosis and treatment of drug, alcohol, Acquired Immune Deficiency Syndrome (AIDS), and psychiatric and psychological disorders including Psychotherapy Notes* as defined by the Health Insurance Portability and Accountability Act 45 CFR 164.501, psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's record, Psychotherapy notes require a separate authorization. It also includes x-rays, reports, progress notes, photographs, lab reports, medical reports, and any and all other documents of any kind which you have in your possession concerning or relating to any injury, treatment or disability sustained by the above named individual. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputed, resolutions and payments, medical records provided as evidence of services provided. This listing is not meant to be exclusive.

I, the undersigned individual, am on notice that:

- Initiating this request for disclosure of protected health information, and any disclosure of the same pursuant hereto is at the request of the individual.
- Any health care provider disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.
- This authorization can be revoked through written notice to the individual above listed entities, except to the extent that action as been taken in reliance on this authorization. The undersigned is aware of the potential that protected health information disclosed pursuant to this authorization is subject to re-disclosure in a manner that will not be protected by HIPAA regulations.
- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until settlement or final disposition of _____ **v. _____**or five (5) years from the date of this authorization, whichever comes later.

I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Date: _____ _____
(Signature) Patient or Patient Representative

_____ _____
Printed Name of Patient's Representative Relationship to Patient

_____
Description of Representative's Authority to Act for the Patient

**Psychotherapy notes includes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnostic functional status, the treatment plan, symptoms, prognosis, and progress date.*