HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the released information may be subject to redisclosure by the recipients and no longer be protected by federal privacy regulations.

Patient Name:	Date of Birth:
Persons/organizations authorized to provide the information:	

TRISTAR Risk Management, P.O. Box 2805, Clinton, IA, **52733** is authorized to receive and use/redisclose the information in connection with my claim for worker's compensation benefits. I further authorize that a photocopy of this medical release may be used by **TRISTAR Risk Management (TRISTAR)** to order and obtain medical information.

Specific description of information: complete medical record for all dates of service and all admissions including, but not limited to: history and physical exam; progress notes; office notes and letters; office chart; laboratory reports; diagnostic test reports including, but not limited to, x-ray, MRI, CT scan, bone scan, thermography reports; x-ray, MRI, CT scan, bone scan, thermography films; inpatient admissions and discharge reports; outpatient and emergency room admissions; complete hospital chart; healthcare records in your file from other providers; prescription records; operative reports; physical therapy.

The purpose of use or disclosure of patient information is for my worker's compensation claim. Patient information may be used or disclosed to administer, determine and/or litigate my claim. Patient information may be redisclosed to the parties, their agents and representatives; to the Division of Workers' Compensation; authorized Independent Medical Examiners including the Division of Labor Medical Examiners; Division of Administrative Hearings; vocational experts; entities involved in a third party action arising out of the Workers' Compensation matter, County and/or District Courts; and any of my past or present health care providers.

I understand that this authorization will expire upon the closure of my Colorado worker's compensation claim.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, revocation will not affect any actions the provider took before it received the revocation. Also, I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by a revocation.

I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form.

I understand that I am entitled to receive a copy of this authorization.

_______________________________________   _______________________________
Signature of patient or patient's representative   **Date**

Address: ____

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If a patient's representative signs this authorization, please complete the following:

____
Printed name of patient's representative

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Relationship to the patient

Describe the representative's authority to act for the patient:_______________________________________