Gallagher Bassett Services, Inc.

November 06, 2013

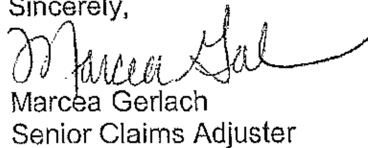
RE:			
	Employer	:	Southwest Water Company
	Employee	:	
	Insured By:		XL Specialty Ins-Admin by Gallagher Bassett Services
	Date of Injury	:	08/23/2013
	Claim Number	:	004376-000085-WC-01

Enclosed please find medical release forms for your signature. Please sign and return them to us as soon as possible.

This information will help us to obtain a clearer picture of your medical history and speed provision of benefits to you, if applicable. Failure to return this form may jeopardize your right to obtain Workers' Compensation benefits.

Thank you for your cooperation in this matter.

Sincerely,



Marcea Gerlach
Senior Claims Adjuster

MG:rs

CC: File

Encl: Medical Release Forms

PO Box 255397
Sacramento, CA 95865
916-929-7581 ext 4488
800-262-0810

Claim Number 004376-000085-wc-01 Claimant Name: Palacios, Lupita

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

To the Applicant: Please list the **names and addresses and phone numbers** of all doctors, hospitals and chiropractors you have seen within the past 5 years. This should include the name of your family doctor, any visits made to hospitals and clinics (even emergency visits) and the name of any other physicians or chiropractors you have seen. If you can remember the year that you were seen by these individuals, please also list. If you have been treated at a Kaiser facility, please specify the location and include your medical record number. **Please date and sign the attached authorization to release medical records or information.**

FAMILY DOCTOR-MEDICAL GROUP:

NAME, ADDRESS, PHONE NUMBERS

____

____

____

HOSPITALS AND CLINICS:

NAME, ADDRESS, PHONE NUMBERS

1. ______________________________

2. ______________________________

3. ______________________________

CHIROPRACTORS:

NAME, ADDRESS, PHONE NUMBERS

1. ______________________________

2. ______________________________

ANY OTHER PHYSICIANS:

NAME, ADDRESS, PHONE NUMBERS

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

7. ______________________________

Date ______________ SIGN HERE ➔ Signature ______________________

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Claim Number:____________________ Claimant Name:____________________

☒ List of authorized persons or class of persons on Page 1 of 3 attached herein by reference.

☐ ____

☒ **Functions/Class** All providers of health care, health care service plan, pharmaceutical company, or contractor that may disclose the medical information.

AUTHORIZATION TO RELEASE MEDICAL RECORDS OR INFORMATION

I, the undersigned, authorize the above-named provider(s) of services to release to: **Gallagher Bassett Services, Inc.**, their authorized agent Castle Copy Service, attorneys, doctors, examiners or other classes of people that will evaluate your claim, all personal health information (PHI) as described; medical records, charts, notations, correspondence, reports, photographs, films, except as specifically excluded below:

____

or, only the following records or types of health information and /or only on the specified dates:

Date(s) of Treatment:__________Type of Treatment: ____________________

The disclosure of records authorized herein is required for the following purpose only:
For administration of claim

This authorization shall become effective immediately and shall remain in effect as long as is necessary for **Gallagher Bassett Services, Inc.** to administer your Claim, but nevertheless shall expire 2 years from the date of your signature.

This is an informed consent for the release of my records, and I have a right to receive a copy of this authorization upon request. A photocopy of this signed authorization shall be deemed as valid as the original.

I understand that such information may be used by other parties necessary to participate in processing my claim. Such re-disclosure may no longer be protected by state or federal confidentiality laws. However, California law prohibits the re-disclosure of medical information without obtaining a new authorization or unless otherwise required by law. If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

I have asked questions about anything that was not clear to me, and I am satisfied with the answers received.

Claim Number:______________________ Claimant Name:______________________

This consent is subject to revocation by the undersigned in writing at any time by sending revocation to **Gallagher Bassett Services, Inc.** and to the list of care providers listed on page 1, except to the extent that action has been taken in reliance herein, and if not earlier revoked, it shall terminate on the conclusion of my case without express revocation. If I revoke this authorization, it will not have any affect on actions taken by all parties in reliance of it before I revoked it.

I acknowledge that I am aware that the consequences of my not signing this authorization can include a delay in the processing/resolution of the (my) claim, a potential denial of the claim, or other consequences recognized by applicable state law and /or the insurance policy at Issue. The healthcare facility will not condition treatment upon securing a signed authorization.

I have private health insurance: ☐ Yes ☐ No Name of insurance company:______________

A specific authorization is required to disclose information regarding the following:

(check box, sign and date to specify information to be disclosed)	*Signature*	*Date*
☐ I consent to the release of any and all psychiatric treatment records.	______________	_____
☐ I consent to the release of any and all drug / alcohol abuse records.	______________	_____
☐ I consent to the release of any and all HIV Lab Test Results.	______________	_____
☐ I consent to the release of any and all Genetic / Fertility records.	______________	_____

I certify that this medical release authorization was printed in 14-point type when I signed it.
I have received a copy of this authorization.

Fraud Warning: "Any person who makes or causes to be made any knowingly false or fraudulent material statement or material misrepresentation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony."

Dated: ______________ **SIGN HERE ➔** ______________________________

(Signature)

______________________________ ______________________________

(Name and relationship of party other than patient signing) (Patient name)

____

(Date of birth)

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."