AUTHORIZATION FOR RELEASE OF UNION RECORDS

TO:

RE: **(Plaintiff's name)** _____

_____

_____

Date of Birth: _____

Social Security No.: _____

You are hereby authorized and directed to release and provide _____ or its representatives any and all records, including but not limited to the types of records listed below and including but not limited to all electronically generated or stored records:

1. Application for membership;
2. Yearly income including number of hours/days worked per year;
3. Names and addresses of any and all employers, locations of worksites including any job and/or work logs;
4. All pension related information including documents showing pension contributions by employers;
5. Documentation of any training participation and information regarding training materials or trade literature received;
6. Records of any grievances filed or claims made for work-related injuries;
7. Records of all claims for health, accident, pension or disability benefits;
8. All records pertaining to any claim for injuries allegedly due to exposure to asbestos or other materials in the course of his employment;
9. All medical reports and records, infirmary records, return to work slips, medical excuses and accident reports; and
10. Records pertaining in any manner to any health screening or educational sessions in which the aforementioned person participated regarding his claimed exposure to asbestos or other materials or conditions during the course of his employment.

Copies of the above-referenced materials should be numbered. A photostatic copy of this Authorization shall be considered as effective and valid as the original.

DATED this ____ day of _____ 200____.

_____

(Plaintiff's name)

AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

TO:

RE: **(Plaintiff's name)**_____
_____
_____

Date of Birth: _____

Social Security No.: _____

You are hereby authorized and directed to release and provide _____ or its representatives any and all records, including but not limited to the types of records listed below and including but not limited to all electronically generated or stored records:

1. Attendance records;
2. Records of claims made for work-related injuries;
3. Records of all claims for health, accident or disability benefits;
4. All records pertaining to any claim for injuries allegedly due to exposure to asbestos or other materials in the course of his employment;
5. All medical reports and records, infirmary records, return to work slips, medical excuses and accident reports;
6. Records pertaining in any manner to any health screening or educational sessions in which the aforementioned person participated regarding his claimed exposure to asbestos or other materials or conditions during the course of his employment;
7. All logs and/or other records reflecting work at off-site work locations;
8. Application and/or resume;
9. Employee evaluations and/or training records; and
10. Changes in position and/or pay raises.

Copies of the above-referenced materials should be numbered. A photostatic copy of this Authorization shall be considered as effective and valid as the original.

DATED this ____ day of _____ 200____.

_____
(Plaintiff's name)

AUTHORIZATION FOR RELEASE OF MILITARY RECORDS

TO:

RE: **(Plaintiff's name)** _____
_____
_____

Date of Birth: _____

Social Security No.: _____

Armed Forces Identification No.: _____

Dates & Branch of Service: _____

You are hereby authorized and directed to release and provide _____ or its representatives any and all records, including but not limited to the types of records listed below and including but not limited to all electronically generated or stored records:

1. Medical records and all records of any physical examinations,
2. All records showing dates and places of the above examinations;
3. All records of discharge from the Armed Forces; and
4. All records concerning medals, awards or other honors received; including but not limited to all electronically or computer stored or generated records.

Copies of the above-referenced materials should be numbered. A photostatic copy of this Authorization shall be considered as effective and valid as the original.

DATED this ____ day of _____, 200____.

_____
(Plaintiff's name)

AUTHORIZATION FOR RELEASE OF SOCIAL SECURITY RECORDS

TO:

RE: **(Plaintiff's name)**_____

_____

_____

DOB: _____

SS#: _____

You are hereby authorized and directed to release and provide _____ or its representatives any and all records pertaining to any claim for benefits, including but not limited to the types of records listed below and including but not limited to all electronically generated or stored records: applications for disability or supplemental security income benefits, transcripts of testimony, statements, medical records, medical evaluations, findings, adjudications, orders, briefs and correspondence.

Copies of the above-referenced materials should be numbered. A photostatic copy of this Authorization shall be considered as effective and valid as the original.

DATED this ____ day of _____, 200____.

_____

(Plaintiff's name)

AUTHORIZATION FOR RELEASE OF WORKERS' COMPENSATION RECORDS

TO:

RE: **(Plaintiff's name)** _____

_____

_____

Date of Birth: _____

Social Security No.: _____

You are hereby authorized and directed to release and provide _____ or its representatives any and all records in the entire Worker's Compensation or Occupational Disease file, including but not limited to the types of records listed below and including but not limited to all electronically generated or stored records:

1. All investigation records;
2. Statements, depositions, notes of conversations;
3. Medical records and bills;
4. Records of payment; and
5. Application for adjustment of claim, settlement contracts, transcripts and other Industrial Commission records; including but not limited to all electronically or computer stored or generated records.

Copies of the above-referenced materials should be numbered. A photostatic copy of this Authorization shall be considered as effective and valid as the original.

DATED this ____ day of _____, 200____.

This information release does <u>not</u> authorize you to discuss my case.

_____

(Plaintiff's name)

AUTHORIZATION FOR EXAMINATION AND COPY OF TAX RECORDS

REQUESTING ATTORNEY: _____

RE:
DOB:
SS#:

I. AUTHORIZATION TO REQUESTING ATTORNEY: This authorizes the addressee or any of his, her or its record custodians or attendants to:

A. permit examination, in the presence of a records custodian or agent, of any and all records, including but not limited to the types of records listed below and including but not limited to all electronically generated or stored records:

The _____(years) income tax records and any and all other tax records you may have in your possession regarding _____; and

B. furnish or arrange for copying for such records, as requested by the "REQUESTING ATTORNEY" or his representative, (hereafter "REQUESTING ATTORNEY").

II. A COPY OF THIS AUTHORIZATION SHALL HAVE THE SAME FORCE AND EFFECT AS THE ORIGINAL.

I. THE RECORDS PROVIDER IS REQUESTED TO LIST ANY AND ALL DOCUMENTS IN THE PROVIDER'S POSSESSION WHICH ARE NOT BEING PRODUCED AND THE REASON WHY THE RECORDS ARE NOT BEING PRODUCED.

III. COPIES OF THE ABOVE-REFERENCED MATERIALS SHOULD BE NUMBERED.

_____ _____

DATE

AUTHORIZATION FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (MEDICAL RECORDS) PURSUANT TO HIPAA

To: **(Health care Provider)**

Re: **Patient's Name:**_____ **Date of Birth:** _____

Patient's Address: _____

Social Security No.: _____

I. **RECORDS/INFORMATION TO BE DISCLOSED:** This authorization applies to any and all of the records or documents in your control or possession, whether or not created by you, including but not limited to the types of records listed below and including but not limited to all electronically generated or stored records:

A. All records, reports, test results of other documents concerning the medical care, treatment, and examination of the aforementioned patient;

B. All pathology, that is not necessary for care and treatment, original tissue blocks, original tissue slides, wet tissue, records, self histories, histochemical and immunochemical reports, autopsy reports, including but not limited to hand-written notes and/or drawings associated with the autopsy, test results, other documents, or electronic information concerning the medical care, treatment, and examination of the aforementioned person, including any photomicrographs, Millipore filters, written tissue digestion protocol or other material related in any way to any lung tissue asbestos fiber burden analysis or ferruginous body study performed on the tissues of the aforementioned patient;

C. Copies of all correspondence concerning the medical care, treatment, examination, or physical condition of the aforementioned patient;

D. Copies of bills or statements of services rendered for such service;

E. X-ray films, MRI films, CT films and all other imaging films involving the aforementioned patient.

II. **PERSONS, FACILITY, ORGANIZATION, OR CLASS OF PERSONS AUTHORIZED TO DISCLOSE RECORDS/INFORMATION:** The following persons or organizations are authorized to make the requested use or disclosure of my above-identified protected health information:

_____

III. **PERSONS, FACILITY, ORGANIZATION AUTHORIZED TO RECEIVE THE RECORDS/INFORMATION:** The following persons or organizations are authorized to receive my above-identified protected health information:_____**, or its representative(s).**

IV. **PURPOSE FOR AUTHORIZATION** - This authorized use or disclosure is for the following specific purpose(s): at the request of the individual Patient/or Patient's Representative for **Use in civil litigation in a civil action brought by Plaintiff(s).**

V. **EXPIRATION OF AUTHORIZATION** - This authorization will expire upon the following event: **Final resolution of the above-identified civil action.**

VI. **AUTHORIZING SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE: I authorize the use or disclosure of the records/information described below and:**

- I am not required to sign this authorization and may in fact refuse to sign this authorization.
- I understand that the authorized health care provider will not condition my treatment or payment for my treatment on my signing this authorization.
- I understand that if the person or entity that receives the described records/information is not subject to federal privacy regulations or other laws, the records/information may be re-disclosed and no longer protected by those regulations.
- I also understand that certain records may be protected by federal or state law, including HIV, psychiatric or mental health treatment, alcohol/drug treatment or communicable diseases, and I am requesting that any and all such protected records be released under this authorization.
- I know that I may inspect or copy the protected health information sought to be used or disclosed in this authorization as permitted by the federal privacy regulations.
- I know that I have the right to revoke this authorization at any time. My revocation must be in writing and must bear my signature. My revocation must be submitted to the authorized health care provider disclosed above.
- I understand that if I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on this authorization.
- I have discussed this authorization with my attorney and he has advised me of my rights pursuant to HIPAA.
- **This authorization does <u>not</u> waive my doctor/patient privilege.**

Copies of the above-referenced materials should be numbered. A photostatic copy of this Authorization shall be considered as effective and valid as the original.

THIS AUTHORIZATION DOES <u>NOT</u> AUTHORIZE DISCUSSION OF THE MEDICAL CARE AND/OR CONDITION OF THE ABOVE PARTY. This Authorization is for securing copies of the medical records, X-Rays films, CT films, MRI films, bills, pathology, and office notes only as described herein. This does not authorize the securing of a narrative medical report, nor does it authorize the bearer to conduct ex-parte interviews with any medical personnel regarding the treatments and conditions.

I certify that I have read, signed, and received a copy of this authorization.

_____ _____

Signature of Patient (or Patient's Representative) **Date of Signature**

_____

Patient Representative's Relationship/Capacity to Patient

_____

Printed name of Personal Representative

_____

Address and Telephone number of Personal Representative