

AUTHORIZATION FOR RELEASE OF INFORMATION

MCSFile: _____

Name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip Code: _____

I. General Release.

I hereby authorize _____ to disclose the information set forth in Section IV of _____ [Name and address of record source: e.g., Employer]

this Authorization for the period from _____, _____ to _____, _____. The released information is required for litigation. I further authorize The MCS Group, Inc., a private record reproduction company, upon presentation of this authorization or a copy thereof, to photocopy such records as are reasonably necessary for the above-state purposes.

II. Health Information Release. I hereby authorize the disclosure of my health information, as described in this authorization:

a.) Person(s) authorized to disclose the information: _____ [Name of the Provider: Hospital, Doctor, Insurance Co.]

b.) Information to be disclosed: The Information set forth in Section V of this Authorization. I understand that the health information may include information pertaining to treatment of drug and alcohol abuse, mental health including without limitation psychiatric information, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, sick cell anemia treatment, tuberculosis information or genetic information. THIS INFORMATION WILL BE RELEASED UNLESS I INDICATE OTHERWISE BY CHECKING HERE: _____

c.) Person(s) authorized to receive the disclosed information: The MCS Group, Inc. on behalf of: _____ [Name of MCS Client]

I further authorize The MCS Group, Inc., a private record reproduction company, upon presentation of this authorization or a copy thereof, to photocopy such records as are reasonably necessary for the above-state purposes.

d.) Purpose of this request: At my request.

e.) Expiration Date: Unless otherwise revoked, this authorization will expire one year after the date of this authorization or later as indicated here _____.

f.) Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying in writing each Person identified in Section (a). I understand that the revocation is only effective after it is received and logged by such Person. I understand that any disclosure made prior to the revocation under this authorization will not be affected by the revocation.

g.) Subsequent Disclosure: I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

h.) Impact on Medical Treatment: I understand that I do not need to sign this authorization to assure any medical treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer for each Person identified in Section (a).

III. Signature/Certification.

Signature of Person Identified Above or his or her Authorized Representative / Guardian _____ Date _____

By signing this authorization, the Authorized Representative and/or Guardian warrants that he or she has the authority to act on behalf of the person identified above on the basis of: _____

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IV. Information Subject to the General Release.	
<input type="checkbox"/>	<p style="margin: 0;"><u>Provider</u></p> <p style="margin: 5px 0 0 0;"><u>Employment</u> Copies of any and all records including but not limited to all applications for employment, all prior employment verification information, all pre-employment background or health documentation, applications for insurance, insurance forms, all physician or medical reports or records of any kind pertaining to physical examination required for employment, continued employment, or health or disability insurance, all reports or records of job or other injury, attendance records, sick time records, vacation records, payroll records, W-2 forms, salary history, progress records, letters of complaint, layoffs or termination for any and all times, occasions or reasons, pertaining to the Person identified on the front of this Authorization Form.</p>
<input type="checkbox"/>	<p style="margin: 0;"><u>Car Insurance</u> Copies of any and all claims files concerning claims including but not limited to PIP pay out sheets, medical records, bills and reports of treating an examining physician's statements of claims, correspondence, notes and documents concerning of any and all property damage claims files including but not limited to photographs, estimates, appraisals, payouts for property damage, and any documentation regarding property damage. Insured: Person identified on the front of this Authorization Form.</p>
<input type="checkbox"/>	<p style="margin: 0;"><u>Social Security Benefits</u> Any and all records showing all payments and benefits received, and all benefits still available and not used by the Person identified on the front of this Authorization Form, including but not limited to any and all disability benefits, application for benefits, approval or denial of benefits and other social security benefits records regarding the above mentioned individual.</p>
<input type="checkbox"/>	<p style="margin: 0;"><u>School</u> Copies of any and all school records, transcripts, attendance records, disciplinary reports, extracurricular activities, and cumulative records regarding the Person identified on the front of this Authorization Form.</p>
<input type="checkbox"/>	<p style="margin: 0;"><u>Other</u></p>
V. Information Subject to the Health Information Release.	
<input type="checkbox"/>	<p style="margin: 0;"><u>Provider</u></p> <p style="margin: 5px 0 0 0;"><u>Employment</u> Copies of any and all records including but not limited to all applications for employment, all prior employment verification information, all pre-employment background or health documentation, applications for insurance, insurance forms, all physician or medical reports or records of any kind pertaining to physical examination required for employment, continued employment, or health or disability insurance, all reports or records of job or other injury, attendance records, sick time records, vacation records, payroll records, W-2 forms, salary history, progress records, letters of complaint, layoffs or termination for any and all times, occasions or reasons, pertaining to the Person identified on the front of this Authorization Form.</p>
<input type="checkbox"/>	<p style="margin: 0;"><u>Pharmacy</u> Any and all prescription records kept in the regular course of business including but not limited to prescription prescribed, physicians prescribing medications, medication description, medication side effect print out, frequency medication being taken, billing, insurance and payment records, etc., and any and all records kept in your file regarding the below listed party; from the first date of treatment to the present (pertaining to the Person identified on the front of this Authorization Form).</p>
<input type="checkbox"/>	<p style="margin: 0;"><u>Medical Insurance</u> Copies of any and all claim files concerning claims made by the below listed party including but not limited to pay out sheets, medical records, bills and reports of treating and examining physicians, state of claims, correspondence, notes and documents concerning any payments made to medical providers under the provisions of the policy. Insured: (the Person identified on the front of this Authorization Form).</p>
<input type="checkbox"/>	<p style="margin: 0;"><u>Medical</u> Copies of any and all medical records, reports, charts, notes, diagrams, documents, papers, correspondence, memoranda, microfilmed document emergency room reports, billing information, x-ray films, MRI films, and/or films or of radiological studies and any and all other records of reports in your possession, custody or control, from the inception of your records to the present pertaining to the Person identified on the front of this Authorization Form.</p>
<input type="checkbox"/>	<p style="margin: 0;"><u>Other</u></p>