Protective Insurance Company

1099 North Meridian Street, Ste. 700
Indianapolis, IN 46204
(317) 636-9800

Claim# _____

Authorization to Release Information

I authorize and request the disclosure of all protected information by any licensed physician, hospital, clinic or other medical or related facility, insurance company, government organization, Social Security Administration, employer, or other organization, institution or person that has any records or knowledge of me, my health, (including any information relating to use of drugs or use of alcohol and any information relating to mental and physical history, condition, advice or treatment), my earnings or other insurance benefits to release this information to Baldwin and Lyons, Protective Insurance Company, and all duly authorized representatives. I expressly request that the designated records custodian of all entities covered under HIPAA disclose full and complete protected medical information for the purposes of administering any claims for benefits.

This consent shall be subject to revocation at any time except to the extent that the entity or person which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will expire upon final termination of all claims between the claimant and Baldwin and Lyons, Protective Insurance Company, and any duly authorized representatives.

I further understand that in executing this authorization, information obtained by it will be used for evaluating and administering any and all insurance claims made for benefits and that I have waived the right for such information to be privileged.

A photocopy of this authorization shall be as effective and as valid as the original.

_____

Claimant's Signature (Insured, otherwise authorized person) Date

_____

Claimant's Printed Name Date

(Version Date: 10/2010)

AUTHORIZATION FOR RELEASE OF

PATIENT HEALTH INFORMATION

PATIENT NAME: _____
CLAIM NUMBER: _____

REQUESTOR: Protective Insurance Company

I, the undersigned, hereby authorize the following health care providers:

1._____Phone_____

Address_____

2._____Phone_____

Address_____

3._____Phone_____

Address_____

4._____Phone_____

Address_____

To release any and all medical information including but not limited to mental health records protected by the Lanteman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any to an agent, designee or representative of the Requester for the specific purpose of handling my workers' compensation claim in compliance with the appropriate governing codes including California Civil Code Section 56 et seq,. California Evidence Code Section 1158. et. Al.

This authorization is effective now and will remain in effect for one year following the execution of this authorization.

I understand I have the right to receive a copy of this authorization.

Signed: _____ Date: _____

Print Name: _____

Signed: _____ Date: _____

Print Name: _____

Date of Injury: _____ Claimant: _____