Claims | Claims Management of Missouri, LLC | Mgmt of MO

AUTHORIZATION TO INSPECT & COPY MEDICAL RECORDS

PATIENT INFORMATION:
Printed Name:______________________________ Date of Birth:____________________
Address:____
Social Security: _____________________________ Telephone:______________________

I hereby authorize: "ANY & ALL Health Care Provider(s)"

to release the following information to:
CLAIMS MANAGEMENT OF MISSOURI, LLC
16100 Chesterfield Parkway West – Ste. 210
St. Louis, Mo. 63017

Information to be released: ANY and ALL records

}Complete Health Record	}Consultation Reports
}X-Ray Films/Images	}History & Complete Physical Exam
}X-Ray Reports	}Itemized Bill
}Laboratory Test Results	}Complete Billing Record
}Photographs, Videotapes	}Discharge Summary
}Diagnosis & Treatment Codes	}Progress Notes

}Other:____

PURPOSE OF REQUEST:
This authorization is being completed at the request of the patient pursuant to litigation. Please note that this authorization includes medical records, reports and other medical documents in your possession, which relate to any prior or subsequent complaints, injuries, illnesses or other conditions involving the same parts of the body and the same or similar conditions described below. This Authorization includes but is not limited to records of all examinations, treatments and tests, including inpatient, outpatient and emergency room, whether for diagnostic or prognostic purposes, consultation reports, correspondence, x-rays, photographs, videotapes, MRI's and CT scans and post-mortem records, if applicable, PROVIDED that the examinations, treatments and/or tests involve or relate to complaints, injuries or illnesses or conditions pertaining to the following alleged injury:

WORKERS' COMPENSATION CLAIM NUMBER:________________________________

DATE OF ACCIDENT: __________________________

The health care provider is neither required nor prohibited by law from engaging in private conversations regarding the patient's above referenced care. The decision to enter into any such conversation is that of the health care provider. However, disclosure that exceeds the scope of this Authorization may subject the health care provider to civil liability.

DRUG AND/OR ALCOHOL ABUSE AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RECORDS RELEASE:
I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.
___________YES ___________NO

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release.
___________YES ___________NO

EXPIRATION OF AUTHORIZATION:
This Authorization shall remain in effect until the underlying claim is finally resolved. Therefore, you may receive a supplemental request for documents. Provided you have this Authorization allowing you to provide records to the party making the supplemental request, a written request for supplemental documents is sufficient, and no additional Authorization is required. It is expressly agreed that a photocopy of this Authorization shall be as valid as an original.

WHO & WHERE TO SEND / RELEASE INFORMATION:
CLAIMS MANAGEMENT OF MISSOURI, LLC
16100 Chesterfield Parkway West – Ste. 210
St. Louis, Mo. 63017

RIGHT TO REVOKE AUTHORIZATION:
I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. I understand that if I want to cancel/revoke this Authorization, I must mail or fax a letter to Claims Management of Missouri stating that I want to cancel this Authorization.

RE-DISCLOSURE:
I understand that information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE WHO MAY REQUEST DISCLOSURE:
I understand that I do not have to sign this Authorization and my treatment or payment for services will not be denied if I do not sign this form. I understand that I am entitled to a copy of the Signed Authorization and that I can inspect or copy the protected health information to be used or disclosed.

SIGNATURE OF PATIENT: ______________________________

DATE:____________________________

AUTHORIZED SIGNATURE (IF OTHER THAN PATIENT): ______________________________

EMPLOYER CONTACT: ______________________________ **PHONE NUMBER:** ______________________________