

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Claim or Policy Number:

Name:

Address:

Birthdate:

This will authorize WORKSITE SOLUTIONS, a unit of COMBINED INSURANCE COMPANY OF AMERICA, PO Box 6700, Scranton, PA 18505-0700 to obtain necessary medical information for the purposes of evaluating my insurance claim. The information to be obtained shall include information from all health care providers, employer, consumer reporting agency, any other insurance company, or the "MIB" (Medical Information Bureau), which is relevant to my loss or condition being evaluated.

The information to be disclosed may include but is not limited to:

History of Present Illness  
Operative Reports  
Daily Doctor's Notes  
X-Ray Reports

Consultant's Reports  
Pathology Reports  
Past Medical History  
Other (Specify):

Discharge Summary  
Laboratory Results  
Previous Admissions

The information is needed for the following purpose(s):  
Evaluation and processing of my insurance claim

I understand that the information released by this authorization may also include information concerning treatment of physical and mental illness, HIV, alcohol/drug abuse and past medical history.

I understand that upon fulfillment of the above stated purposes, this consent will automatically expire six (6) months following date of signature without any express revocation. I understand I have the right to revoke this authorization at any time, and in order to do so, I must present a written revocation to Combined Insurance Company of America. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy or evaluate my insurance application for coverage.

Federal and state laws protect the information disclosed pursuant to this authorization. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by the federal confidentiality rules. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining the individual's authorization.

\_\_\_\_\_  
(Signature of Patient or Guardian)

Date: \_\_\_\_\_  
(Must be filled in)

\_\_\_\_\_  
(Signature of Witness)

\_\_\_\_\_  
(Relationship to Patient If Signed by Guardian)

A photocopy of this authorization may be treated in the same manner as an original.