Franklin County
Where Government Works

AUTHORIZATION TO FURNISH MEDICAL RECORDS
AND DISCLOSE PROFESSIONAL AND PERSONAL INFORMATION

List the providers you are authorizing on the following page.

Name: _____ Date of injury: _____

SSN: _____ Address: _____

DOB: _____ City, State, Zip Code _____

TO WHOM IT MAY CONCERN:

I, _____, hereby authorize you and/or any other hospital, medical institution, doctor or medical practitioner, insurance company, pharmacy, school board, employer, U.S. Defense Department, Veteran's Administration, Social Security Administration, or any agency of any state, county or municipality, or employee of any of the above or any provider who has given me medical and/or psychological treatment, to furnish and release to the Office of the Franklin County Commissioners, or any of its authorized representatives or agents, any and all reports, records, files, and information pertaining to treatment of injuries sustained on date above.

This Authorization includes, but is not limited to, x-ray films, x-ray reports, pathology slides, tissue blocks, nurses' notes, diagnostic testing results, emergency room records and bills for services and applies from the past fifteen years from the date of this signed release to the present. This Authorization also applies to files and information regarding alcohol, drug and psychiatric/psychological reports, records, HIV test result, AIDS and AIDS related conditions. The sole purpose of this release is to further the administration of a workers' compensation claim(s) by my employer.

I waive and release the attached list of sources or facilities from any restriction imposed by law thereof, in disclosing any record, observation, diagnosis or communication to the Franklin County Commissioners or any of its authorized representatives or agents. I understand and agree that the information I have authorized to be released is exempt from the privacy requirements of the Health Information Portability and Accountability Act (HIPAA), pursuant to 45 CFR §164.512(e) and (l).

This Authorization is valid for five years from date hereof. I understand that I may revoke this authorization at any time except to the extent that action based on this authorization has been taken. I understand that a copy of this Authorization shall serve in lieu of the original.

_____ _____

Date Employee Signature

Please remit Medical records to: **Sedgwick, CMS**
P.O. Box 14661
Lexington, KY 40512-4661
Fax 614.658.0901

Claimant :
Claim No. :
Employer : Franklin County Commissioners

List of Medical Treatment and Providers

(1) Name _____
Address _____
_____
_____
Telephone _____

(2) Name _____
Address _____
_____
_____
Telephone _____

(3) Name _____
Address _____
_____
_____
Telephone _____

(4) Name _____
Address _____
_____
_____
Telephone _____

(5) Name _____
Address _____
_____
_____
Telephone _____

(6) Name _____

Claimant :
Claim No. :
Employer Franklin County Commissioners

List of Medical Treatment and Providers

Address _____

_____

_____

Telephone _____

(7) Name _____

Address _____

_____

_____

Telephone _____

(8) Name _____

Address _____

_____

_____

Telephone _____

(9) Name _____

Address _____

_____

_____

Telephone _____

(10) Name _____

Address _____

_____

_____

Telephone _____