AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH

INFORMATION TO DISCOVERY INSURANCE COMPANY

1. I hereby authorize_____
(name of facility from which records are to be released)

to release the following specific information to DISCOVERY INSURANCE COMPANY:

____Copy of complete medical records relative to treatment for a work-related injury of_____.

____Copy of complete medical records for a period of ten (10) years prior to my work-related injury of_____.

_____Other: I give express consent for a representative from the health care facility releasing records to discuss or otherwise communicate directly, outside my presence, with a representative from Discovery Insurance Company, and/or their designee, regarding the treatment provided relative to my work-related (or claimed work-related injury), including but not limited to: records, report of injury, diagnostic testing, diagnoses, ability to return to work, work restrictions, physical and/or psychological limitations, and recommendations for further treatment or care. Covering and limited to information relative to a work-related injury of:_____.

2. By initialing, I also agree to release of the following information:
_____a. Test(s)/ screening for the presence of antibodies to the HIV virus, the virus that causes Acquired Immunodeficiency Syndrome (AIDS).
_____b. Documentation or medical treatment relating to the diagnosis of AIDS/HIV.
_____c. Treatment for psychiatric matters, or alcohol and/or drug abuse.

3. The PURPOSE or NEED for this disclosure of this information is evaluation and management of my worker's compensation claim.

4. I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND THAT ENROLLMENT IN AND ELIGIBILITY FOR BENEFITS UNDER THE NORTH CAROLINA WORKER'S COMPENSATION ACT WILL NOT BE AFFECTED IF I DO NOT SIGN THIS FORM. I UNDERSTAND THAT THIS AUTHORIZATION CAN BE REVOKED AT ANY TIME BY GIVING WRITTEN NOTICE OF REVOCATION TO THE DISCOVERY INSURANCE COMPANY, EXCEPT TO THE EXTENT THAT A DISCLOSURE HAS BEEN MADE IN GOOD FAITH RELIANCE ON THIS DOCUMENT. I ALSO UNDERSTAND THAT INFORMATION PROVIDED MAY BE SUBJECT TO BE DISCLOSED BY THE ENTITY RECEIVING THE INFORMATION, IN WHICH CASE PRIVACY PROTECTION MAY BE LOST.

5. This authorization for Release of Information (unless expressly revoked earlier) expires once the worker's compensation claim is resolved.

Employee Name_____ Date of Birth_____

_____ _____
Employee Signature Date

Information to be faxed to:_____ Fax#:_____ Phone#_____
(Representative of Discovery Insurance Company)