7265 Halcyon Summit Drive
Montgomery, AL 36117-3502
P.O. Box 240549 | 36124-0549
(800) 239-5423
alabamaretail.org

AUTHORIZATION FOR RELEASE OF INFORMATION

1. **I (the undersigned) authorize** any physician, medical professional, pharmacist or other provider of healthcare services, hospital, clinic, other medical or medically related facility; insurance or reinsurance company; government agency; department of labor; acquaintance; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

   Claimant/ Patient Name: _____
   (Last) (First) (Middle)

   Date of Birth: _____ **Social Security Number:** _____

2. Information to be released:
   - data or records regarding my medical history, treatment, prescriptions, consultations, [including medical and psychological reports, records, charts, notes, x-rays, films or correspondence, and any medical condition I may now have or have had];
   - any information regarding insurance coverage; and
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, Retirement Income, financial, earnings, employment history, and personnel records).
3. Information to be released to: Alabama Retail Comp
   P.O. Box 240549
   Montgomery, AL 36124-0549
4. I understand the information obtained by use of this Authorization will be used by Alabama Retail Comp ("Company") to evaluate my claim for Workers' Compensation benefits. The Company will only release such information:
   - to its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
   - as otherwise may be required by law or as I may further authorize.

   I further understand that refusal to sign this Authorization may result in the denial of benefits.
5. I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal law.
6. I understand that I may revoke this Authorization in writing at any time, except to the extent:
   1) the Company has taken action in reliance on the Authorization; or
   2) the Company is using this Authorization in connection with a contestable claim.

   If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of my signature below. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.
7. A photocopy of this Authorization is to be considered as valid as the original.
8. I understand I am entitled to receive a copy of this Authorization.

SIGNATURE: _____ **DATE:** _____
Claimant/ legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/patient is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

PRINTNAME: _____

Relationship to Claimant/Patient of personal/legal representative signing for Claimant/Patient: _____

ADDRESS: _____ **PHONE NO:** _____
Street

_____ **CELL NO:** _____
City State Zip Code

A photocopy of this authorization shall be considered the same as the original