



## *Authorization to Release Information*

**NAME:** \_\_\_\_\_

**SOCIAL SECURITY NUMBER:** \_\_\_\_\_

**MEDICARE NUMBER (HICN):** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**DATE OF INJURY:** \_\_\_\_\_

In compliance with the Federal Privacy Act of 1974 and the HIPAA Privacy Rule, in order for James E. Logan & Associates, Ltd. to assist the employer and insurer in the settlement of the undersigned's workers' compensation claim, the undersigned authorizes a representative of James E. Logan & Associates, Ltd. to communicate with the Centers for Medicare and Medicaid Services (and their contractors), the Social Security Administration, all health insurance payors and any individuals associated with the undersigned's medical care and rehabilitation, and to obtain any and all information about his/her benefits, medical condition, treatment and payments relating to the workers' compensation injury, which occurred on the date listed above.

The undersigned also hereby authorizes any physician, medical practitioner, hospital, medical facility, insurance company, government sponsored health plan, employer, Centers for Medicare and Medicaid Services, Social Security Administration, and all health insurance payors to release his/her information and records to James E. Logan & Associates, Ltd., including any and all information about benefits paid, and any and all information relating to diagnosis, treatment and prognosis of any injury or illness suffered by him/her.

The undersigned also hereby authorizes James E. Logan & Associates, Ltd. to disclose his/her Social Security number with the Centers for Medicare and Medicaid Services (and its contractors), Social Security Administration, his/her employer, employer's insurer, employer's attorney and the undersigned's attorney.

The undersigned understands refusal to authorize disclosure of his/her personal medical information will have no effect on his/her enrollment, eligibility for benefits, or the amount Medicare pays for the health services he/she receives.

This form expires in one year from the date of execution; however, the undersigned may revoke this authorization form by sending a request in writing at any time to:

**The Centers for Medicare and Medicaid Services**  
Post Office Box 33849  
Detroit, MI 48232-0584  
(800) 999-1118

Additionally, revocations may be sent to any other treatment provider or entity of your choice.

**SIGNED:** \_\_\_\_\_

**DATE:** \_\_\_\_\_