DEPARTMENT OF FINANCIAL SERVICES
Division of Risk Management

MEDICAL AUTHORIZATION

The undersigned person(s) hereby consent(s) to, and by this Authorization or any photocopy hereof authorize(s), the release to

_____
Name of Risk Management Adjuster

or any other agent or employee of The State of Florida, Department of Financial Services, Division of Risk Management, by any hospital, medical clinic, surgeon, physician, pharmacist or any other provider of medical services, treatment or supplies to

_____ _____
Name of Patient Date of Birth

any and all medical reports, histories, findings, prognosis, bills, information and other documents relating to any medical treatment, hospitalization, prescription drugs or other medical services or supplies, including psychiatric treatment or treatment for alcoholism or drug abuse, of such patient. This medical authorization concerns a workers' compensation claim.

I, the undersigned individual, am on notice that:
(1) Initiating this request for disclosure of protected health information, and any disclosure of the same pursuant hereto is at the request of the individual.
(2) Information, or certain portions thereof, may be protected from disclosure without this signed Authorization by Federal and State privacy and confidentiality laws.
(3) Any health care provider disclosing the above requested information may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs this authorization.
(4) This authorization can be revoked through written notice to the Division of Risk Management except to the extent that action has been taken in reliance on this authorization. The undersigned is aware of the potential that protected health information disclosed pursuant to this authorization is subject to re-disclosure in a manner that will not be protected by HIPAA regulations.

This Authorization shall automatically expire without express revocation on

_____
List Time or Event

and, prior to such time, shall be subject to revocation with respect to all or any particular records at any time by the undersigned person(s), in writing, delivered to the holder of such records except to the extent that action has already been taken in reliance upon this Authorization.

_____
Date

_____ _____
Name of Patient Date of Birth

If consent is necessary by a parent, guardian or authorized representative, indicate relationship:

_____

_____
Relationship to Patient

_____
Social Security Number of Patient

Form 1407 Purpose and Use statement

The collection of the social security number on this form is imperative for the Division of Risk Management's performance of its duties and responsibilities as prescribed by law under Chapter 284. The social security number will be used as a unique identifier in Division of Risk Management's Risk Management Information System (RMIS) for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in the RMIS regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for adjustment of claims, and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.