



## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION AND OTHER RECORDS

I hereby grant permission to and authorize the use or disclosure of medical records and other protected health information as described below.

**I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.**

**A. Patient Information**

Name: _____	SS#: _____
Daytime Phone Number: _____	Claim Number: _____
Address: _____	Birth date: _____
_____	

**B. Persons/Organizations Providing the Information (if more than listed below, then see attached)**

Doctor or Provider/Hospital Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone #: \_\_\_\_\_

Doctor or Provider/Hospital Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone #: \_\_\_\_\_

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Telephone #: \_\_\_\_\_

Doctor or Provider/Hospital Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone #: \_\_\_\_\_

Doctor or Provider/Hospital Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone #: \_\_\_\_\_



**C. Safeco Entity Receiving the Information**

[Automated insert of company name and address.]

**D. Specific Description of Information**

Any information related to your treatment, the payment of your claim, or other such health care operations related to your claim may be disclosed, including but not limited to the following:

1. Medical Reports, records, charts, notes, and letters: and/or X-rays, films, MRIs, CT-scans and reports
2. Insurance records, including all claims, itemized billing, correspondence, payments, and all documents within the file.
3. Other: \_\_\_\_\_

The above information is being obtained to assist said authorized entities in evaluation my claim for benefits or damages.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Claims Department personnel handling my claim. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire upon closure of the claim initiating the signature of this authorization.

I understand that authorizing the disclosure of this health information is voluntary and that I am entitled to a copy of this authorization and acknowledge receipt of a copy thereof. I can refuse to sign this authorization. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Legal Rep., Relationship to Patient

For more information regarding Safeco's consumer privacy policies, see our "Privacy Policy" hyperlink on the home page of [www.safeco.com](http://www.safeco.com).