WELLFLEET
WORKPLACE

AUTHORIZATION FOR RELEASE OF INFORMATION

Instructions

1. Complete all applicable areas of the following form
2. If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/Claimant's behalf.
3. Sign the form.
4. Return this form as soon as possible to expedite processing of your claim – retain original for your records.

Your refusal to complete and sign this form may affect your eligibility for benefits under the disability plan.

RETURN COMPLETED FORMS AND DIRECT CORRESPONDENCE TO:

WELLFLEET INSURANCE

1500 MAIN STREET, SUITE 1000

SPRINGFIELD, MA 01115

FAX: 413-452-5486

EMAIL: WORKPLACECLAIMS@WELLFLEETINSURANCE.COM

AUTHORIZATION FOR RELEASE OF INFORMATION

☐ Please check this box if you or your authorized representative would like to receive a copy of this form.

Claimant Information: (name of Claimant whose information will be released)

Name: _____ (Last, First, Middle)	Date of Birth: _____/___/_____
Other Name Used: _____	Social Security Number: _____-_____-_____

I authorize any licensed physician, medical provider, hospital, HMO, medical facility, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer to release any and all of the following information to Wellfleet or to persons or other organizations providing claims management services:

Description of the information to be disclosed: I understand that this Authorization for Release of Information specifically includes my permission to disclose my entire record, including medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological medical records (excluding psychotherapy notes); claims history including but not limited to Prescription Drug Databases, pharmacy benefits management companies, ambulance, insurance companies, medical transcripts, or the MIB; and, alcohol or drug abuse including any data protected by Federal Regulation 42 CFR Part 2 or other applicable laws. Information concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable illnesses may be controlled by various laws and regulations at the federal, state or local level. I also understand that work and financial information are necessary to process my claim and I give my permission to disclose related records about me including but not limited to employment, compensation, compensation sources, insurance companies, financial institutions, and government entities. By signing below, I consent to the disclosure of such information but only in accordance with the laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of health and Human Services, once disclosed, may be subject to redisclosure by the recipient as permitted or required by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.

Expiration: Unless revoked as discussed below, This Authorization will be considered valid for a period of twenty-four (24) months from the date this form is signed, or for the duration of the claim for benefits, whichever the shorter.

Right to Revoke: I have the right to revoke this authorization, in writing, at any time by contacting Wellfleet at the address provided on the previous page. I understand that revocation is not effective to the extent that Wellfleet has taken action in reliance on this authorization.

Claimant Rights:

1. I understand that the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. For Colorado claims, the disclosed information may <u>not</u> be redisclosed or reused by the recipient under Colorado law.
2. I understand that a photocopy of this Authorization is to be considered as valid as the original.
3. I understand that I am entitled to receive a copy of this Authorization.
4. I understand that this information may be released to my employer for self-insured plans only.
5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this Authorization.

Authorized Representative Information: Complete this section if a personal representative is authorizing disclosure of the claimant's information. A copy of a power of attorney or other court-initiated document will be required, unless parent signing for patient under 18.

Name: _____ (Last, First, Middle) Relationship to Claimant: _____	Mailing Address: _____ _____ phone: _____-_____-_____