HIPAA COMPLIANT AUTHORIZATION FORM
FOR THE RELEASE OF EMPLOYMENT RECORDS
PURSUANT TO 45 C.F.R. § 164.508

Name or specific identification of the person(s), or class of person. authorized to make the requested disclosure:

_____

Employee Name: _____ A/K/A: _____
Date of Birth: _____ Social Security Number: _____
Address: _____

I authorize disclosure of all protected employment or other confidential information for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities HIPAA identified above disclose full and complete protected medical information spanning the time period of _____ to present including the following:

- All employment information, records and reports, including all tax records, employee reviews, and payroll information.
- All medical information, records and reports, including disability employment applications and disability records.

Information about alcohol/substance abuse and HIV/AIDS may be disclosed as follows: (check all that apply)

____ Yes, disclose HIV/AIDS information
____ Yes, disclose alcohol/substance abuse information

____ No, do NOT disclose HIV/Aids information
____ No, do NOT disclose alcohol/substance abuse information

I authorize you to release the protected health information to **Litigation Management, Inc., 6000 Parkland Boulevard, Mayfield Heights, Ohio 44124.**

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

I acknowledge the right to revoke this authorization by writing to the above noted counsel at the above address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under 45 C.F.R. 164.508.

I acknowledge the right to inspect the material to be released.

I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein. This authorization expires two years from the date below.

Signature: _____ Date: _____
Relationship to person who is the subject of the records:
Self: _____ Other: _____
Describe Authority