HIPAA COMPLIANT AUTHORIZATION FORM
FOR THE RELEASE OF EMPLOYMENT RECORDS
PURSUANT TO 45 CFR 164.508

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

_____

_____

Employee Name: _____

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 under HIPAA identified above disclose full and complete protected medical information, including the following:

- **All employment information, records and reports, including, but not limited to: applications for employment; resumes; records of all positions held; job descriptions of positions held; payroll records; W-2 forms and W-4 forms; performance evaluations, reviews and reports; statements and reports of fellow employees; attendance records; all tax records; insurance claim forms; questionnaires and records of payments made; pension records; all records regarding participation in company-sponsored health, dental, life and disability insurance plans; material safety data sheets; chemical inventories; environmental monitoring records and all other employee exposure records pertaining to all positions held; and any other records concerning employment with the above-named entity.**
- **All medical information, records and reports, including, but not limited to, worker's compensation files, disability employment applications; any records pertaining to medical or disability claims or work-related accidents, including correspondence, accident reports, injury reports and incident reports; all hospital, physician, clinic, infirmary, nurse or dental records; test results; physical examination records and other medical records; disability benefit records; and copies of all x-rays, CT scans, MRI (including MARS MRI) films, photographs/videos, and any other radiological, nuclear medicine or radiation therapy films and any corresponding reports.**

I authorize you to release the protected health information to:

Gibbons P.C.	**The Marker Group, Inc.**
One Gateway Center	**13105 Northwest Freeway, Suite 300**
Newark, NJ 07102-5310	**Houston, TX 77040**

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

The individual signing this authorization expressly authorizes the above-named entity to disclose HIV/AIDS records and information to Gibbons P.C. and/or The Marker Group, Inc., and authorizes re-disclosure of said records and information to consultants, experts, agents, and/or other counsel in this litigation.

The individual signing this authorization understands information authorized for release may include records that may indicate the presence of a communicable disease.

I acknowledge the right to revoke this authorization by writing to Gibbons, P.C. or the Marker Group, Inc. at the above referenced addresses. 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 CFR 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 the person who is the subject of the records:

Self: _____ Other: _____

Describe authority: _____