Claimant:
Claim No.:

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION, MENTAL HEALTH RECORDS AND COMMUNICATIONS RELEASE

I acknowledge and understand that any and all information that may be disclosed pursuant to this authorization may be used by Chubb to perform the insurance functions including, but not limited to, the following: claims administration; claims adjustment and management; investigation of fraud, disclosures that are required to comply with legal process.

I hereby authorize the use and disclosure of my protected health information to Chubb & Son a division of Federal Insurance Company, for itself and as manager of member companies of the Chubb Group of Insurance Companies ("Chubb"). I understand that the purpose of the disclosure is to provide information about my medical condition and treatment related to a workers' compensation claim.

I specifically authorize any treating physician, or medical care provider, psychologist and psychiatrist or mental health counselor to communicate orally or in writing with my employer, its insurer, claims administrator, case managers, or attorneys as to my care and treatment, and as to any other issues including diagnosis, prognosis, causal connection of care and treatment to my work injury of duties, and ability to work. In conjunction with this, I also authorize any treating physician or medical provider to review any additional materials provided to them.

I understand that I may revoke this Authorization, in writing, at any time. However, such revocation will be ineffective for uses or disclosures that have already been made in reliance upon this Authorization. Unless revoked by me sooner, this Authorization shall be effective for the duration of my workers' compensation claim after the date of my signing below.

A photocopy of this Authorization shall be as valid as the original. I understand that I may, at any time, inspect or obtain a copy of this Authorization.

I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE USE AND DISCLOSURE

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
If not Patient, then relationship of Legally Authorized Representative to patient Date

"A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work related injuries or illness without regard of fault." 45 CFR 164.512(1)