Sierra InfoNet

HIPAA-Compliant Authorization For The Release Of Records

1.) I hereby authorize:_____
Name of Facility with Records/Disclosing Party

2.) To disclose to: _____
Name of Requesting Party (Requester): Third Party Administrator/Self-Insured Employer/Attorney Firm

And/or their attorneys, through **Sierra InfoNet their agent**, to review, inspect, and/or photocopy **any and all of the following from any and all dates** which are in your possession or control:

- **Medical Records**, to include but not limited to: Medical files, reports, charts, graphs, notes, tests, x-rays, MRI's, billings and laboratory reports.
- **Employment and/or Union records** to include but not limited to: Personnel file, medical and insurance, pension benefit records and wage records.
- **EDD Disability and Unemployment Records**
- **Insurance and Claim Records**
- **Scholastic Records**
- **Police, Prison or Probation Records**

SENSITIVE INFORMATION: By **marking the boxes** below, I hereby authorize the release of information concerning:

- ☐ **HIV and/or AIDS Information**
- ☐ **Psychiatric and Mental Health Information**
- ☐ **Sexually Transmitted Disease Information**
- ☐ **Alcohol and/or Drug Information**
- ☐ **Genetic Records**

The health information authorized on this form will be used for the following purposes only:

Discovery for a Liability or Workers' Compensation claim.

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ or for ONE full year from date of signature.

REVOCATION: This authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt but will not be effective to the extent that the requester or others have acted in reliance upon this authorization. **Written revocation is to be sent to those parties listed on line 1.) and line 2.) above.**

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use and disclosure is specifically required or permitted by law.

I understand that I have the right to receive a copy of this authorization.
A copy of this authorization shall be considered as valid as the original.

_____ _____ _____
Signature Print Name Date

_____
If Signed by Other than Patient, Indicate Relationship