Claim Number:

GALLAGHER BASSETT SERVICES, INC.
AUTHORIZATION FOR RELEASE OF INFORMATION
(HIPAA COMPLIANT)

Patient Information:

_____ DOB: _____ SS#: _____
(Print Name of Patient)

Information to be released from: _____
Name of Designated Facility or Provider

_____
Address

_____ _____
City, State, Zip Code Phone Number

Additional facility or provider: _____
Name of Designated Facility or Provider

_____
Address

_____ _____
City, State, Zip Code Phone Number

Information to be sent to:

GALLAGHER BASSETT SERVICES, INC.
ATTN: _____
Name of Designated Recipient

_____
Address

_____ _____
City, State, Zip Code Phone Number

Information to be released:

- ☐ The most recent 2 years of pertinent information (chart notes, labs, X-rays and special tests)
- ☒ All medical records
- ☐ Medical Billing
- ☐ Specific information (Please specify) _____

Purpose for which disclosure is being made:

Processing of an insurance claim.
Date of Loss:

Patient Authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*** EXCLUDE the following information from the records released (please initial):**

____	Drug/Alcohol abuse /treatment & diagnosis	____	Sexually Transmitted Disease
____	HIV/AIDS diagnosis/treatment/ testing	____	Mental Illness or psychiatric diagnosis/treatment

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: _____ DATE: _____
(Patient, Guardian*, or Authorized Representative*)
[*Please provide documents to prove authority to sign on behalf of the patient]

SHALL BE VALID FOR ONE YEAR FROM THE ABOVE DATE
PHOTOCOPY VALID AS ORIGINAL

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. `Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."