AUTHORIZATION FOR DISCLOSURE
RELEASE OF HEALTH INFORMATION/MEDICAL RECORDS

Health Insurance Portability and Accountability Act of 1996
45 CFR Subtitle A, Subchapter C, Part 164.512 (e) (1) (iii)

Identification of patient:

____________________ PATIENT'S NAME	____________________ PATIENT'S SOCIAL SECURITY NO.
____________________ PATIENT'S DATE OF BIRTH	____________________ FACILITY/PROVIDER TO RELEASE

Dates of service/treatment to be released: ____________________ **to** ____________________

Class of persons authorized to make the disclosure: All physicians and other health care providers who have examined, treated, consulted with, or x-rayed ____________________ and all hospitals, nursing facilities, rehabilitation facilities, clinics or laboratories in which ____________________ has been a patient and/or resident.

Description of information to be disclosed: You are hereby authorized and directed by the undersigned to give to the bearer of this authorization, or any photostatic copy thereof, any and all information relative to ____________________'s physical, emotional, and mental condition and permit the bearer to examine x-rays, laboratory reports, and medical records of any kind which reflect diagnosis, treatment, prognosis, and any other information concerning illness, injuries, or disability. Such information shall specifically include, but is not limited to, itemized billing records/statements, history & physical, operative reports, lab/pathology reports, consultation reports, physicians' orders, discharge/death summary, x-ray reports/images, other radiographic reports/images, emergency room records, face sheets, nurses' notes, flow sheets, pharmacy and medication records, care plans, assessment tools, screening tools, summaries, social workers, legal, and monitor strips, readouts or printouts. I understand that the specified information to be released may include, but is not limited to: history, diagnosis and/or treatment of drug or alcohol abuse, mental illness, psychological and/or psychiatric treatment, counseling records/notes, genetic testing or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). You are hereby authorized and directed to make available all such information for inspection and copying.

Person or entity to whom information is to be released/disclosed:

Tekell, Book, Allen & Morris, L.L.P.		____________________
1221 McKinney, Suite 4300		____________________
Houston, Texas 77010	or it's agent,	____________________
(713) 222-9542 :Phone		____________________ :Telephone
(713) 655-7727 :Fax		

Purpose of this authorization: At the request of the undersigned individual and for the investigation of a potential claim and for use in potential litigation and litigation including pretrial, trial, post-trial, appeal and any division, extension, continuation or refiling thereof.

Duration of this authorization: This authorization expires one (1) year from the date signed.

I understand that I may revoke this authorization in writing at any time by contacting the Release of Information Dept. at ____, except to the extent that action has been taken in reliance upon the authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected.

I understand that I have a right to a copy of this authorization.

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.

A photostatic copy of this authorization shall be considered as valid as the original.

____________________	X ________________________________
DATE SIGNED	PRINTED NAME OF PERSON LEGALLY AUTHORIZED TO MAKE RELEASE
	X ________________________________
	SIGNATURE OF PERSON LEGALLY AUTHORIZED TO MAKE RELEASE
	________________________________
	CAPACITY OF PERSON LEGALLY AUTHORIZED TO MAKE RELEASE (if self state "self")

Before me, the undersigned authority, on this day personally appeared ____________________________, known to me to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he/she executed the same for the purposes and considerations therein expressed.

Given under my hand and seal of office this ________ day of ______________________, 20____.

____
NOTARY PUBLIC

My Commission Expires: _____________

UTMB USE ONLY: **Please check one: _____ HIM to release PHI _____ PHI already has been released; HIM to only file Authorization**

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) By UTMB

Patient Name: ______________________________ ______________________________

Last First M.I. (Previous Or Other Names Used)

Address: ______________________________

Date of Birth: ______________________________ **UH Number:** ______________________________

If this Authorization is for any purpose other than the release of PHI for personal reasons, please state the purpose below:

____

I authorize the release of medical records from: The University of Texas Medical Branch

301 University Blvd. Galveston, Texas 77555

____

Please release requested medical records to:

Name: ______________________________

Address: ______________________________

City: ______________ State ______ ZIP ______

Telephone Number: ______________ Fax Number: ______________

I specifically authorize the use and disclosure of the following PHI: **(Please provide a detailed description of the particular data and period of time you are requesting)**

☐ Emergency Records	______	☐ Hospital Records	______
☐ Clinic Records	______	☐ Radiology Reports	______
☐ Lab Reports	______	☐ Radiology Films	______
☐ Shot Records	______	☐ Pathology Reports	______
☐ Slides	______	☐ Other	______

This authorization will expire on the 180th day of the signing unless a lesser date is specified below:

____

By signing this Authorization Form, I understand that I am giving my authorization for UTMB to use and/or disclose my protected health information (PHI) as described above. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care. If you are requesting psychotherapy session notes maintained by a mental health provider, a separate authorization form must be completed. I understand that I may revoke this authorization at any time by notifying UTMB in writing to the Health Information Management Department, 301 University Blvd, Galveston, Texas 77555-0782 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by UTMB before UTMB received my written notice of revocation. If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization Form. I understand that I am not required to sign this Authorization Form in exchange for the patient receiving treatment from UTMB.

______________________________ ______________

Signature of Patient or Authorized Personal Representative **Date**

____

Relationship to the Patient (If signed by a Personal Representative)

IF PATIENT ID CARD IS UNAVAILABLE, WRITE DATE, PT NAME AND UH# IN SPACE BELOW

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) BY UTMB

Medical Record Form 7032-Rev.5/05
The University of Texas Medical Branch Hospitals
Galveston, Texas

Original-Medical Record

UTMB FORMS MGT. STRICTLY PROHIBITS CHANGES TO THIS FORM.

AUTHORIZATION FOR RELEASE OF PSYCHOLOGICAL TESTING RECORDS, INCLUDING RAW DATA

I, ________________________________, Social Security Number: ______________,
(print complete name)

Date of Birth: ______________, specifically authorize any psychiatrist, psychologist, counselor, physician, medical doctor, hospital or clinic, or their representatives, including, but not limited to, ____________________________________, to deliver to Tekell, Book, Allen & Morris, L.L.P., 1221 McKinney, Suite 4300, Houston, Texas 77010, or their designated representative, including licensed psychiatrist or psychologist, ____, a complete copy of all of my mental health and medical records and bills, including, but not limited to all psychological testing records including raw test data. I understand that photocopies or facsimiles of this authorization may be made and distributed to multiple healthcare providers and that a photocopy or facsimile of this authorization is as valid as the original. This authorization will expire upon the conclusion of my case in the above styled and numbered cause.

____
Patient / Plaintiff

SUBSCRIBED AND SWORN TO before me on this the ______ day of ____________, 20____.

____
NOTARY PUBLIC IN AND FOR
THE STATE OF TEXAS

AUTHORIZATION FOR RELEASE OF EMPLOYMENT, PERSONNEL AND PAYROLL RECORDS

TO WHOM IT MAY CONCERN:

This will authorize you to release to TEKELL, BOOK, ALLEN & MORRIS, L.L.P., or their representatives, any and all employment, personnel and payroll records pertaining to ______________________ which are in your possession or subject to your control, for inspection and copying of same, PROVIDED:

1. The employment, personnel and payroll records include all such records related to employment including but not limited to: all 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 and reports; statements and reports of fellow employees; attendance records; workers' compensation files; hospital, physician. clinic, nurse, psychiatric and dental records; x-rays, test results, physical examinations and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made, pension records, disability benefit records, and records regarding participation in company-sponsored health, dental, life and disability insurance plans, material safety data sheets, chemical inventories, and environmental monitoring records and any other employee exposure records pertaining to all positions held; and any other records concerning employment with the above-named institution.

2. You are specifically and expressly authorized to accept a copy of this authorization as though it were an original; and,

3. You are specifically and expressly released from any liability which would otherwise arise from the release of this information.

____
Signature

____
Printed Name

____
Social Security No.

____
Date of Birth

SUBSCRIBED AND SWORN TO before me on this the ______ day of ____________, 20__.

____
NOTARY PUBLIC IN AND FOR
THE STATE OF TEXAS

AUTHORIZATION TO RELEASE EDUCATION RECORDS

TO: ____

____

____

I, ____, authorize the above named to release any and all education records requested in the attached subpoena/notice pertaining to ____, DOB: _______________, SSN: _______________, to Tekell, Book, Allen & Morris, L.L.P., on behalf of Kenneth Tekell and/or Mike Morris, attorneys for Defendant, 1221 McKinney, Suite 4300, Houston, Texas 77010.

The education records are being released for pending civil litigation. A notice has been duly served upon the student's attorney, ____.

____
Printed Name

____
Signature

SUBSCRIBED AND SWORN TO before me on this the _____ day of ____________, 20_____.

____
NOTARY PUBLIC IN AND FOR
THE STATE OF TEXAS

Form **4506**

(Rev. January 2010)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Request may be rejected if the form is incomplete or illegible.**

OMB No. 1545-0429

Tip. You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return,** or you can call 1-800-829-1040 to order a transcript.

1a Name shown on tax return. If a joint return, enter the name shown first.

1b First social security number on tax return or employer identification number (see instructions)

2a If a joint return, enter spouse's name shown on tax return.

2b Second social security number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

4 Previous address shown on the last return filed if different from line 3

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.

Caution. *If the tax return is being mailed to a third party, ensure that you have filled in line 6 and line 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy.*

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ ______________

Note. *If the copies must be certified for court or administrative proceedings, check here* . . . . ☐

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

8 **Fee.** There is a $57 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.**

a	Cost for each return	$ 57.00
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☐

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note.** *For tax returns being sent to a third party, this form must be received within 120 days of signature date.*

Telephone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) — Date

▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** — Date

Form **4506-T**
(Rev. January 2010)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▶ **Request may be rejected if the form is incomplete or illegible.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can also call 1-800-829-1040 to order a transcript. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.

1b First social security number on tax return or employer identification number (see instructions)

2a If a joint return, enter spouse's name shown on tax return.

2b Second social security number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

4 Previous address shown on the last return filed if different from line 3

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.

Caution. *If the transcript is being mailed to a third party, ensure that you have filled in line 6 and line 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy.*

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ ____________

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120A, Form 1120H, Form 1120L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 30 calendar days. . ☐

c **Record of Account,** which is a combination of line item information and later adjustments to the account. Available for current year and 3 prior tax years. Most requests will be processed within 30 calendar days . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2007, filed in 2008, will not be available from the IRS until 2009. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 45 days . . . ☐

Caution. *If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.*

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

____________ ____________ ____________ ____________

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note.** *For transcripts being sent to a third party, this form must be received within 120 days of signature date.*

Telephone number of taxpayer on line 1a or 2a

Sign Here

Signature (see instructions) — Date

Title (if line 1a above is a corporation, partnership, estate, or trust)

Spouse's signature — Date

AUTHORIZATION FOR RELEASE OF EMPLOYMENT AND PAYROLL RECORDS

I, hereby consent for you to release to McLEOD, ALEXANDER, POWEL & APFFEL, P.C., or their representative, all information (confidential or otherwise) which you possess or records which are in your possession or under your control relating to my personnel or wage earnings record. I hereby waive the confidentiality thereof, and authorize you to make full disclosure of such records.

This release and authorization is signed for the purpose of enabling the attorneys herein named to investigate my claim for damages in any Court or administrative proceeding in connection with the claim which I am now asserting that I am entitled to damages or compensation because of damage or harm to my body.

In complying with this request, you are directed to furnish to said attorneys, at their expense, all information concerning the personnel and wage earning records of ____________. A photocopy of this authorization may be accepted in lieu of the original.

X ______________________________
Signature

X ______________________________
Date of Birth

X ______________________________
Social Security Number

AUTHORIZATION TO RELEASE INFORMATION

(To be completed and signed by each individual Plaintiff alleging exposure to Texas City Refinery Ultracracker emission event April/May 2010)

FULL LEGAL NAME: ______________________________

SOCIAL SECURITY NUMBER: ______________ DATE OF BIRTH: __________

DATE OF DEATH: ____________ MEDICARE NUMBER (HICN): __________

DATE OF INJURY[1]: ______________________________

NAME OF PERSONAL REPRESENTATIVE (Deceased Plaintiff)[2]: ______________

In compliance with the Federal Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this authorizes the Centers for Medicare & Medicaid Services (CMS), and their contractors, to release to Tekell, Book, Allen & Morris, L.L.P. ("Authorized Party"), or its representatives, any and all information concerning conditional payments made by Medicare to or on behalf of the above named injured party resulting from injury/illness and/or settlement for the specified personal injury which occurred on the date listed above and to ______________________________.

The undersigned also hereby authorizes the Authorized Party to disclose the injured party's Social Security number to CMS and their contractors.

The undersigned also hereby authorizes Authorized Parties to disclose the injured party's Social Security number to the Social Security Administration to determine social security benefits (for the purposes of determining Medicare eligibility).

A copy of this form will have the same force and effect as the original. This form expires one year from the date of execution; however the undersigned may revoke the authorization form by sending a request in writing at any time to the appropriate office below:

MSPRC
Liability
P.O. Box 33828
Detroit, MI 48232
Tel (866) 677-7220 Fax (734) 957-0998

SIGNED: ______________________________ DATE: ____________________

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1 In the event that alleged injury involved exposure, date of injury is the date when Plaintiff was first alleged exposed.

2 If this form is executed by the Personal Representative of Plaintiff, attach proof of representation (i.e., Letters Testamentary, Court Order, etc.)

1-800-MEDICARE Authorization to Disclose Personal Health Information

Use this form if you want 1-800-MEDICARE to give your personal health information to someone other than you.

1. **Print Name** (First and last name of the person with Medicare) ____________ **Medicare Number** (Exactly as shown on the Medicare Card) ____________ **Date of Birth** (mm/dd/yyyy) ____________

2. Medicare will only disclose the personal health information you want disclosed.

   2A: **Check only <u>one</u> box below to tell Medicare the specific personal health information you want disclosed:**

   ☐ Limited Information (go to question 2b)

   ☐ Any Information (go to question 3)

   2B: **Complete <u>only</u> if you selected "limited information". Check all that apply:**

   ☐ Information about your Medicare eligibility

   ☐ Information about your Medicare claims

   ☐ Information about plan enrollment (e.g. drug or MA Plan)

   ☐ Information about premium payments

   ☐ Other Specific Information (please write below; for example, payment information)

   ____

3. **Check only <u>one</u> box below indicating how long Medicare can use this authorization to disclose your personal health information** (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

   ☐ Disclose my personal health information indefinitely

   ☐ Disclose my personal health information for a specified period only beginning: (mm/dd/yyyy) __________ and ending: (mm/dd/yyyy) __________

4. **Fill in the name and address of the person(s) or organization(s) to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person(s) for any organization you list below:**

   1. Name: ______________________________

      Address: ______________________________

      ____

   2. Name: ______________________________

      Address: ______________________________

      ____

   3. Name: ______________________________

      Address: ______________________________

      ____

5. **I authorize 1-800-MEDICARE to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.**

   X ______________________ X ______________________ ______________________

   Signature | Telephone Number | Date (mm/dd/yyyy)

   Print the address of the person with Medicare (Street Address, City, State, and ZIP)

   X ____

   X ____

   ☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, Power of Attorney). This <u>only</u> applies if someone other than the person with Medicare signed above.

   Print the Personal Representative's Address (Street Address, City, State, and ZIP)

   ____

   ____

   Telephone Number of Personal Representative: ______________________

   Personal Representative's Relationship to the Beneficiary: ______________________

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

August 2003

AUTHORIZATION FOR USE AND RELEASE OF HEALTH INFORMATION

SECTION I

Name________________________ **D.O.B.**__________ **Medicaid ID# (if known)**__________**SSN#**__________

By signing this authorization form, you are giving the Texas Health and Human Services Commission (HHSC) permission to release all or part of your Medicaid claims history, which includes health information.

SECTION II – To be completed by Client

I authorize HHSC to release the information indicated in Part A below to the person or agency named in Part A below, for the purpose(s) stated in Part B below. My information will remain available to the person or agency indicated until the expiration date stated in Part B.

Part A – Release of Information: I understand that my Medicaid claims history contains protected health information.

Check one of the following:

- ☐ **Release all of my Medicaid claims history**
- ☐ **Release only the parts of my Medicaid claims history that relate to:**
  - **the following health care provider:** ______________________________
  - **other (please describe in detail the health information you authorize HHSC to release):**

    ____

    ____

Release my information to the following Person/Agency: ______________________________

Part B - Purpose(s) of Release: ____

This authorization expires on: ________________

Part C - Signature______________________________________ **Date:** ______________
(Client or Personal Representative's Signature)

If you are signing for the client, please describe your authority to act for the client on the following line:

____

Note: If the person requesting the release of my Medicaid claims history cannot sign his/her name, a witness to his/her mark (X) must sign below:

___________________________________ __________________
Witness **Date:**

SECTION III – Notices to Client

- **Once you authorize HHSC to release your information, HHSC is not responsible for any redisclosure of the information by the recipient.**
- **You can withdraw permission you have given HHSC to use or disclose health information that identifies you, unless HHSC has already taken action based on your permission. You must withdraw your permission in writing.**
- **With a few exceptions, you have the right to request and be informed about the information that the Health and Human Services Commission (HHSC) releases. You are entitled to receive and review the information upon request. You also have the right to ask HHSC to correct information that is determined to be incorrect (Government Code, Sections 552.021, 552.023, 559.004). If you would like HHSC to correct information about you that is incorrect, please contact the HHSC Privacy Office at 4900 N. Lamar Blvd., 4th Floor, Austin, Texas 78751.**

CITY OF HOUSTON FIRE DEPARTMENT - EMERGENCY MEDICAL SERVICES AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Read the instructions on page 3 carefully before completing this form.

This authorization is meant to comply with and satisfy the requirements of the Health Insurance Portability and Accountability Act ("HIPAA"), Title 45, Part 164 of the Code of Federal Regulations and Chapter 773 of the State of Texas Health and Safety Code. Pursuant to these laws, the undersigned states as follows:

Section I: PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
SOCIAL SECURITY or OTHER IDENTIFICATION#	DATE OF BIRTH:	

Section II: Voluntary Authorization to Release Medical Services Records

I, ______________________________, voluntarily authorize the City of Houston, its agents,
Patient, Legal Guardian, or Authorized Representative

servants, employees, officials, and attorneys to release, to person listed in Section IV of this form, the following Emergency Medical Service records (i.e., documents, audio and video recordings, etc.), maintained by the City of Houston, for the above-referenced patient for medical services provided on ______________________.
Date of Service

Section III: Description of Information Authorized for Release (*See* Instructions on Page 3 to complete this section.)

a. ☐ Entire Emergency Medical Services Record, except sensitive information described in (e) below.

b. ☐ Only information related to (specify): ______________________________
____

c. ☐ Only records related to events during the period from ____________ to __________

d. ☐ Other (specify): ____

e. If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health (Other than Psychotherapy Notes)

Section IV: Name and Address of Person or Organization to Receive Patient's Health Information
(Please Print)

Name: ____
Address: ____
____
____

Section V: Purpose of Release (*See attached instructions*)

Please provide the purpose for the use or disclosure:
____
____

Section VI: Expiration Date or Event

Please provide a date or event upon which you wish this authorization to expire: ______________________
____

If you fail to specify an expiration date or event, this authorization will expire one year from the date it was signed. If you choose to specify an expiring event, you must provide the City with an actual date at the time that this authorization is signed or by written notice sent to: City of Houston Fire Department - Emergency Medical Services Records Division located at: 500 Jefferson, Suite# 1600, Houston, Texas 77002. If the City does not receive written notice containing the actual date of expiration, the City will continue to rely on this authorization for one year from the date it was signed.

Section VII - Right to Revoke

I understand that I may revoke or withdraw this authorization, in writing, submitted at any time by submitting a revocation to the City of Houston Fire Department - Emergency Medical Services Records Division located at: 500 Jefferson, Suite# 1600, Houston, Texas 77002, except to the extent that the City of Houston Fire Department has already used or disclosed the requested protected health information in reliance on my authorization.

Section VIII - Permitted Redisclosure

I understand that the information, disclosed under this authorization, is subject to redisclosure by the recipient and is no longer protected health information. I also understand that withdrawal of consent does not affect any information disclosed before the date on which written notice of withdrawal was received.

I understand that authorizing the use or disclosure of the above-identified information is voluntary. I also understand that I do not need to sign this form to ensure health care treatment.

Section IX - Photocopies of Authorization

I agree that a photocopy of this form will have the same effect as the original.

Section X - Charges for Photocopies of Records

I understand that the City of Houston will charge for photocopies of the requested record(s) according to the schedule provided by sections 2-98 and 2-99 of the City of Houston Code of Ordinances.

Section XI - Patient's Right to Refuse Signature and Obtain Copies

I understand I am entitled to inspect or copy the protected health information to be used or disclosed. I understand I have the right to refuse to sign this authorization and I am willing to sign this authorization.

Section XII - Agreement Not to Sue the City for Release Under This Authorization

I agree not to claim damages or sue the city, or any of its employees or elected or appointed officials, for releasing the medical information as authorized by me in this document.

Section XIII - Patient/Authorized Representative's Signature and Date

PLEASE READ THIS ENTIRE FORM, INCLUDING THE INSTRUCTIONS, CAREFULLY BEFORE SIGNING THIS FORM.

SIGNED on this the ____ day of ________________________, 20 _______.

____

SIGNATURE OF PERSON CONSENTING TO THE RELEASE OF HIS OR HER RECORDS <u>OR</u> SIGNATURE AND PRINTED NAME OF AUTHORIZED REPRESENTATIVE

____

PRINTED NAME AND ADDRESS OF THE PERSON CONSENTING TO THE RELEASE OF RECORDS

NOTE: If the person signing this form is an authorized personal representative, please provide a description of such representative=s authority to act for the individual below **and**, if other than a parent of a minor or dependent child, attach a copy of the power of attorney, evidence of guardianship, or other document authorizing representation:

____

____

STATE OF TEXAS §
§
COUNTY OF ________________ §

BEFORE ME, the undersigned authority, on this day personally appeared ______________________________, whose identity has been proven to me, and who, after being duly sworn did depose, acknowledge and swear that he/she executed the foregoing **CITY OF HOUSTON FIRE DEPARTMENT - EMERGENCY MEDICAL SERVICES AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION** in his/her capacity as set out above, as his/her free act and deed, and that he/she is over the age of eighteen (18) years and is of sound mind.

GIVEN under my hand and seal of office on this ___ day of ________________, 20 ______.

____

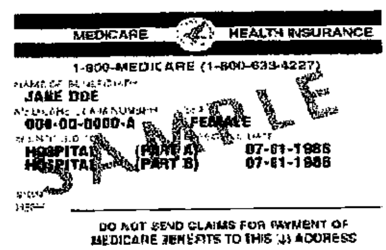
NOTARY PUBLIC IN AND FOR
THE STATE OF TEXAS

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?		□Yes	□No
If yes, please complete the following. If no, proceed to Section II.			
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*			
Medicare Claim Number:	**Date of Birth (Mo/Day/Year)** - -		
Social Security Number: *(If Medicare Claim Number is Unavailable)* - -	Sex	□Female	□Male

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) **Claim Number**

Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature of Person Completing This Form **Date**

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

______________________________ ______________________________

Claimant Name (Please Print) **Claim Number**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

____

____

____

____

X______________________________ ______________________________

Signature of Person Completing This Form **Date**

MMSAS Section 111 Compliance Form

GENERAL INFORMATION

(1) Plaintiffs' Full Legal Name (No initials – No Nicknames)	(2) Other Names by Which Plaintiff Is Known (Nicknames)

(3) Plaintiff's Current Address	(4) Case C.A. No.	(6) Is It Alleged That The Plaintiff Alleging Exposure In This Case Was Exposed To Asbestos After 12/05/1980? ☐ Yes ☐ No

(7) Gender ☐ M ☐ F	(8) date of Birth	(9) date of Death	(10) Social Security No.

(11) List All Injuries To The Body That Plaintiff Believes Resulted From The Exposure(s) Alleged (include specific reference to each part of the body injured)

(12) Does The Plaintiff Have Any Form Of Kidney Disease? ☐ Yes ☐ No	(13) Type of Kidney Disease	(14) Date Of Diagnosis	(15) Describe Treatment Received	(16) Prognosis
(17) Does The Plaintiff Have End Stage Renal Failure? ☐ Yes ☐ No	(18) Date of Diagnosis	(19) Has An Application Been Made To Medicare Or Medicaid (For Renal Failure)? ☐ Yes ☐ No	(20) Renal Failure Application Date	(21) Renal Failure Health Insurance Claim Number (HCIN)

MEDICARE/MEDICAID BENEFITS

(22) Has Plaintiff Enrolled In or Applied For Medicare or Medicaid ☐ Yes ☐ No	(23) Application Date	(24) Health Insurance Claim Number (HICN)	(25) Date Eligibility Began

(26) If Plaintiff Is Deceased, Were Medical Bills For Treatment Which Are The Basis Of This Law Suit paid By Medicare/Medicaid? ☐ Yes ☐ No	(27) If Plaintiff Is Deceased, Were Medical Bills For Treatment Which Are The Basis Of This Law Suit Submitted To Medicare/Medicaid? ☐ Yes ☐ No

SOCIAL SECURITY DISABILITY INSURANCE BENEFITS

(28) Has Plaintiff Applied For Social Security Disability ☐ Yes ☐ No	(29) Application Date(s)	(30) Denial Date(s)	(31) Stated Reasons For Denial(s)
	(32) Appeal Date(s)	(33) Appeal Outcome(s)	(34) Date(s) of SSD Award(s)
(38) List The Injuries Claimed That Resulted in SSDI Benefits Awarded	(39) List The Date The Injury Occurred For Which SSDI Benefits Were Awarded	(40) List The Beginning date that SSDI Benefits Covered	(41) List The Period For Which SSDI Benefits Were Paid (Beginning and ending dates inclusive)

I HEREBY DECLARE UNDER OATH THAT THE RESPONSES GIVEN IN THE ABOVE FORM ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND I ACKNOWLEDGE THAT A FALSE STATEMENT HEREIN IS PUNISHABLE AS PERJURY.

Date : ____________________

____
Signature of Plaintiff

INSRUCTIONS: This form is to be completed and signed by each individual Plaintiff. If completed and executed by the Personal Representative of any individual Plaintiff, print name of Representative below and attach proof of representation (i.e., Letters Testamentary, Court Order, etc.). Do not leave any blocks blank. Note "N/A" if and where appropriate. Attach additional sheets, individually signed, if necessary and refer to the numbered block for which the additional sheet is attached. The information provided on this form is to be kept current and supplements are to be provided as necessary.

Printed Name of Personal representative (If Applicable) : ____________________________

FORM B

MEDICARE CONFIDENTIAL REPORTING INFORMATION FORM

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007

Case Name:	Case Number:

Is the injured party presently or has he/she ever qualified for or been enrolled in Medicare Part A or B? ☐ Yes ☐ No

Section A **ALLEGED INJURED PARTY INFORMATION** *(If party is DECEASED, also complete Section F)* *Please see footnote at bottom of page

4. Medicare Claim Number *(also known as HICN)*

5. Social Security Number:	6. Injured Party Last Name: *(Please print name exactly as it appears on Social Security card.)*
7. Injured Party First Name: *(Please print name exactly as it appears on Social Security card.)*	8. Injured Party Middle Name: *(Please print name exactly as it appears on Social Security card.)*

9. Gender: ☐ Male ☐ Female	10. Date of Birth: *(MM/DD/YYYY)*	Deceased? ☐ Yes ☐ No

Section B **ALLEGED INCIDENT INFORMATION**

12. CMS Date of Incident: Please state the date of accident or date of first exposure, ingestion, implantation with respect to settling defendant's product and/or premises.

13. Industry Date of Incident: Please state the date of accident or date of last exposure, ingestion, or implantation with respect to settling defendant's product and/or premises.

15. Alleged Cause of injury, illness or incident: Please state the alleged cause of injury, incident or illness and the ICD-9-CM (InternationalClassification of Diseases, Ninth Revision, Clinical Modification code(s)) with respect to the same.****

17. State of Venue	19. ICD-9 Diagnosis Code 1: Please provide valid ICD-9 Codes for any injury or illness you allege arose from the allegations made against settling defendant. NOTE: separate ICD-9 codes are required for each body part you assert was/is affected. **

21. ICD-9 Diagnosis Code 2:	23. ICD-9 Diagnosis Code 3:	25. ICD-9 Diagnosis Code 4:	27. ICD-9 Diagnosis Code 5:	29. ICD-9 Diagnosis Code 6:
31. ICD Diagnosis Code 7:	33. ICD-9 Diagnosis Code 8:	35. ICD-9 Diagnosis Code 9:	37. ICD-9 Diagnosis Code 10:	39. ICD-9 Diagnosis Code 11:
41. ICD-9 Diagnosis Code 12:	43. ICD-9 Diagnosis Code 13:	45. ICD-9 Diagnosis Code 14:	47. ICD-9 Diagnosis Code 15:	49. ICD-9 Diagnosis Code 16:

51. ICD-9 Diagnosis Code 17:	53. ICD-9 Diagnosis Code 18:	55. ICD-9 Diagnosis Code 19:

57. Description of Illness/Injury (Free Form Text Description): ***

*NUMBERS REFLECT CLAIM INPUT FILE FIELD NUMBERS AS SET FORTH IN VERSION 2 OF THE OFFICIAL NGHP USER GUIDE

** CLAIMS SUBMITTED PRIOR TO 1/1/11 **MUST** PROVIDE EITHER: (1) **BOTH** A VALID ALLEGED CAUSE OF INJURY, INCIDENT OR ILLNESS CODE (FIELD 15) **AND** AT LEAST ONE VALID DIAGNOSIS CODE IN THE ICD-9 DIAGNOSTIC CODE 1 (FIELD 19) **OR** THE DESCRIPTION OF INJURY ILLNESS (FIELD 57)

CLAIMS SUBMITTED ON OR AFTER 1/1/11 **MUST** CONTAIN **BOTH** THE ALLEGED CAUSE OF INJURY, INCIDENT OR ILLNESS CODE (FIELD 15) **AND** THE ICD-9 DIAGNOSTIC CODE 1 (FIELD 19).

***FIELD 57 IS **REQUIRED** THROUGH 12/31/10 IF NO ALLEGED CAUSE OF INJURY, INCIDENT OR ILLNESS CODE (FIELD 15) **OR** NO ICD-9 DIAGNOSTIC CODE 1 (FIELD 19) IS PROVIDED.

****THE CURRENT LIST OF VALID CODES ACCEPTED BY CMS FOR SECTION 111 REPORTED MAY BE FOUND AT: www.cms.hhs.gov/ICD9ProviderDiagnositcCodes/06_codes.asp.

The information in this form is to be held confidential and not used in discovery or in any proceeding in evidence or otherwise, except to communicate with the U.S. Government or its designee or to defend any claim of lien or fine pursuant to Medicare statutes, rules and regulations including MMSEA Section 111.

FORM B

Case Name:	Case Number:

Section C	ALLEGED INJURED PARTY'S ATTORNEY OR OTHER REPRESENTATIVE INFORMATION			
84. Representative Type (please check one): ☐ A=Attorney ☐ G=Guardian/Conservator ☐ P=Power of Attorney ☐ O=Other				
85. Representative Last Name:	86. Representative First Name:	87. Representative Firm Name:		
88. TIN/EIN, if Firm Entity; Social Security Number if individual:	89. Mailing Address:			
91. City:	92. State:	93. Zip Code +4:	95. Phone:	96. Ext. (if any):

Section D	SETTLEMENT INFORMATION	
Name of Settling Defendant:	100. Date of Settlement:	101. Amount of Settlement:
102. Funding Delayed Beyond TPOC (actual or estimated date of funding):		

Section E	SIGNATURE ✘

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Name of Attorney representing Plaintiff/Claimant	Date	Printed Name

(The signature of the attorney hereto constitutes a certificate by him/her that he/she has read the information supplied in this Form and that all information stated therein is well grounded in fact to the the best of his/her knowledge, information and belief formed after reasonable inquiry.)

If you have completed this page in its entirety and Alleged Injured Party in Section A is not deceased, stop here.

FORM B

Case Name:	Case Number:

ATTENTION

If Alleged Injured Party is NOT DECEASED and you have completed Page 1 & 2, you may stop here.

Please continue to Section E (Claimant Information) only if Alleged Injured Party in Section A is deceased.
At least Claimant 1 information is required if Alleged Injured Party is deceased.

FORM B

Case Name:	Case Number:

Section F **CLAIMANT INFORMATION** *(Use only if Alleged Injured Party in Section A is deceased.)*

CLAIMANT 1

104. Claimant Relationship to Alleged Injured Party:	☐ E=Estate (Individual)	☐ X=Estate (Entity)	☐ O= Other (individual)
	☐ F=Family (Individual)	☐ Y=Family (Entity)	☐ Z=Other (Entity)

105. TIN/EIN, if Entity; Social Security Number, if Individual:	106. Claimant Last Name:
X	X

107. Claimant First Name:	108. Claimant Middle Initial:
X	X

109. Claimant Entity/Organication Name:

110. Mailing Address:
X

112. City:	113. State:	114. Zip Code +4	116. Phone:	117. Ext. (if any):
X	X	X	X	

119. Claimant Representative Type:	☐ A=Attorney	☐ P=Power of Attorney
	☐ G=Guardian/Conservator	☐ O=Other

120. Claimant Representative Last Name:	121. Claimant Representative First Name:	122. Claimant Representative Firm Name:

123. TIN/EIN, if Firm/Entity; Social Security #, if individual:	124. Representative Mailing Address:

126. City:	127. State:	128. Zip Code +4	130. Phone:	131. Ext. (if any):

Counsel for Claimant 1	Date	Printed Name

(The signature of the attorney hereto constitutes a certificate by him/her that he/she has read the information supplied in this Form and that all information stated therein is well grounded in fact to the the best of his/her knowledge, information and belief formed after reasonable inquiry.)