Medical Release (HIPAA Compliant)

Patient:

Workman's Compensation / No-Fault Injury Sustained on:

Date of Birth:

MEDICAL CARE PROVIDER: The following health provider is authorized to provide medical records and disclose patient identifiable health information:

Thai-Issan Therapeutic Massage LLC

The above named health provider is authorized to discuss my medical treatment and health information with my attorney, _____ Attorney at Law, and his designated agents and consultants, my Physician, _____, **MD** as well as my Workman's Compensation or No-Fault Insurance Carrier strictly for the purpose of facilitating my ongoing Treatment Plan and the associated Billing for Services Provided for the above named injury.

The above named health provider is **NOT** authorized to discuss my medical treatment or health information with any other third party without my express written permission

MEDICAL RECORDS TO BE PROVIDED:

Prescription Diagnosis and appropriate ICD-9 or ICD 10 Codes to be used strictly for the purpose of billing my Workman's Comp or No-Fault Insurance Carrier

PROVIDE MEDICAL RECORDS TO:

Thai-Issan Therapeutic Massage LLC
655 Keeaumoku St Suite 102
Honolulu, HI 96814

PURPOSE: The patient identifiable health information received pursuant to this release authorization is to be used strictly for the following purposes.

Workman's Compensation and (or) No-fault (PIP) insurance claims, liability claims, underinsured motorist claims, and all other insurance or legal matters related to my injuries or health condition relating to the above incident.

RIGHT OF REVOCATION: I have the right to revoke this release authorization at any time. The revocation must be in writing and be delivered to all parties having access to my personal medical information. Such revocation will not apply to records and information that have already been provided.

EXPIRATION: Unless earlier revoked, this authorization will expire one year after the date of this release or upon the completion of my claims relating to the above incident, whichever is later.

PATIENT RIGHTS: I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect and amend my medical records as provided in 45 CFR 164.526. I have the right to an accounting of the use and disclosure of my health information to any third party as provided in CFR 164.528. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining my authorization or my signing this release authorization.

RE-DISCLOSURE: I understand that there is a potential for unauthorized re-disclosure of the information and that the re-disclosed information may not be protected by federal confidentiality rules.

PHOTOCOPIES OF THIS RELEASE ARE VALID AND MAY BE USED IN LIEU OF THE ORIGINAL.

DATE: _____ SIGNATURE: _____

Email to: thaiissanusa@gmail.com or Fax: (808)593-8035