Mobile Copy Service HIPAA Compliant Authorization to Release INSURANCE Records

Fill in Patient Information in Boxes BELOW

Claimant Name:	Date of Birth:	Date of Incident:
Claim Number(s):	Policy Number(s):	

I, the undersigned, request that information regarding my insurance claim(s)/policy(ies) be released as set forth on this form. I authorize the following facility to release this information to **Mobile Copy Service** or it's representatives, on behalf of the following company/requestor:

Fill in Insurance Company Name, Address of where you want us to Copy Records and Name of Policy Holder BELOW

Insurance Carrier:
Insurance Address:
Insured Name (Policy Holder):

I, the undersigned, request that the facility listed above release the following insurance information:

Release The Following: *(indicate by checking appropriate box below)*

- ☐ Any and All Claim(s) Information on All Claim(s).
- ☐ Any and All Policy(ies) Information on All Policy(ies).
- ☐ Only Records Pertaining to Claim #: _____
- ☐ Only Records Pertaining to Policy #: _____
- ☐ Other: _____

Make Sure to CHECK all Boxes that Apply ABOVE

I, the undersigned, understand that this information will be used for the sole-purpose of aiding the Attorney/Insurance Company in determining the nature and extent of injuries, damage, wages/earnings lost, and for the establishment of liability of claim for benefits & compensation. Also, it is understood that this authorization does not condition any treatment and/or payment. I, the undersigned, understand that once the requested information is disclosed to the requesting party, it may be re-disclosed by the recipient and may no longer be protected by State or Federal Law. This authorization does not permit any other person/company, other than Mobile Copy Service, to obtain these records. Mobile Copy Service will not re-disclose any information regarding the patient other than to the party listed below and/or any of its representatives.

Fill in Attorney/Insurance Name BELOW

Requesting Attorney/Insurance Company:
Requestor's Case/Claim Number:

I, the undersigned, have the right to revoke this authorization at any time notifying, in writing, the facility at the address above, and Mobile Copy Service at 325 Maple Ave Torrance, CA 90503. I may revoke this authorization in writing at any time, except to the extent that the facility has already replied to the authorization by releasing the requested records. Also, I have read and received a copy of this authorization and acknowledge that a photocopy of this form shall be as valid as the original.

Be Aware of the Year of Expiration date is Written

This authorization shall remain in effect for a maximum of one (1) year unless a different expiration date is indicated here: _____ *(indicate expiration date).*

✘ _____ ✘ _____

Signature of Patient/Guardian/Personal Representative — Today's Date

Must be Signed by Patient — Must be Dated

✔ If NOT signed by the patient, print signer's name: _____

✔ If NOT signed by the patient, indicate legal relationship to patient: _____