ACCLAMATION INSURANCE
MANAGEMENT SERVICES

P.O. Box 269120
Sacramento, CA 95826-9120
(916) 563-1900

Re: **Employee:** **Tiffany Anderson**
Employer: **San Joaquin County MVCD**
Claim No.: **VE0700184**
Date of Injury: **06/19/2008**

AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL, EMPLOYMENT, SOCIAL SECURITY, SCHOLASTIC, AND INSURANCE RECORDS

I, , hereby authorize all health/medical/insurance providers and/or employers, not limited to physicians and hospitals, to furnish any/all of my personnel/employment records, Social Security Administration records, scholastic records, insurance claim files and medical records, past and present, including for personal and industrial injuries to:

Acclamation Insurance Management Services
P.O. Box 269120
Sacramento, CA. 95826

The disclosure of records authorized herein is to be used by AIMS for purposes of review, investigation, evaluation and/or processing of a workers' compensation claim.

I further release my attending physician and his/her associates and the hospital and its employees and agents from liability from the release of this information or records to such designated person or agencies.

This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier, it shall remain valid for one year from the date signed.

This authorization is pursuant to California Evidence Code Section 1158, when applicable. A photocopy of this signed release may be used in lieu of an original.

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

I further understand that I have a right to receive a copy of this authorization upon my request.

We ask that you list all medical providers you have seen in the past five years regardless of whether it was work related or not.

Medical Provider Name Address/Phone # Year Seen Specialty

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Employee's Signature Date

_____ _____

Employee's Address Employee's Phone #

Acclamation Insurance Management Services, Inc.
PO Box 269120 • Sacramento, CA 95628
Phone: (916) 563-1900 • Fax: (916) 563-1919 • www.aims4claims.com

NAME:_____ DATE:_____

Employer: San Joaquin County MVCD	**Claim No:** VE0700184	**Date of Injury:** 06/19/2008

Under the California Worker's Compensation Law, You are entitled to reimbursement of reasonable mileage to and from medical appointments or treatment for your industrial injury or illness. Mileage will be reimbursed at the following rates

Prior to 7/1/06 .34
7/1/06 to 12/31/06 .445
1/1/07 to 12/31/07 .485
1/1/08 Forward .505

DATE	FROM	TO (DOCTOR'S NAME)	ROUND TRIP MILEAGE

If you desire additional forms, please check here_____ TOTAL MILES_____

Signature:_____