EXAMWORKS CLINICAL SOLUTIONS
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED
HEALTH INFORMATION PURSUANT TO HIPAA AND APPOINTMENT OF REPRESENTATIVE
(Health Insurance Portability and Accountability Act of 1996)

I hereby authorize the use or disclosure of my Protected Health Information and other information as described below. I understand that this authorization is voluntary.

Individual/Claimant: _____ Individual/Claimant SSN: _____

Individual/Claimant Address: _____

Medicare/Health Insurance Claim Number (HICN) #: _____ Date of Injury: _____

Medicaid/Medicare Advantage Plan #: _____ Date of Birth: _____

Persons/ Entities authorized to provide the information:
Any health plan, physician, healthcare professional, hospital, clinic, laboratory, holders of prescription information, including but not limited to, pharmacies, pharmacy benefit managers, and insurers, medical facility, employer, health insurance payers, the Centers for Medicare & Medicaid Services, MyMedicare.gov, Social Security Administration, Medicaid, the BCRC, or any other healthcare professional that has provided payment, treatment or services to me or on my behalf.

Persons/ Entities authorized to receive, use, and disclose the information:
1. ExamWorks Clinical Solutions
   2397 Huntcrest Way, Suite 200
   Lawrenceville, Georgia 30043
2. Centers for Medicare & Medicaid Services (CMS)
3. Designated private Medicare Advantage Plan as contracted through Medicare (CMS):
   _____

Description of Information:
1. Entire medical record, prescription history, medications prescribed, eligibility, prescribing physician, pharmacy information, bills, insurance coverage information and any other protected health information concerning me. This includes information on the diagnosis and/or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.
2. Any information as may be requested by ExamWorks Clinical Solutions from any person/entity authorized to provide the information, which, in ExamWorks Clinical Solutions' sole discretion, is required or necessary to accomplish the purpose of this Authorization.

Purpose of Authorization:
1. This Authorization for use or disclosure of information is at the request of the individual/claimant.
2. To provide a full disclosure of any information to ExamWorks Clinical Solutions, to enable it to evaluate, determine, and prepare a recommended Medicare Set-Aside, and to complete any other applicable and requested services, including Conditional Payments (Medicare Lien) Research, Final Lien Amount Demand and Lien Negotiation, Medicaid or Medicare Advantage Plan lien research and negotiation.
3. To designate ExamWorks Clinical Solutions as its representative to have the authority to communicate with CMS, the BCRC, a state Medicaid agency and any private Medicare Advantage Plan or Medicare Advantage Organization (as specifically designated above) to obtain Conditional Payment information and to dispute or negotiate, on my behalf, any request for Conditional Payment Reimbursement related to the undersigned Medicare beneficiary.

I acknowledge and understand the following:
1. That if the person or entity authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations;
2. That my health care, payment of health care, treatment, enrollment, eligibility for benefits, or the amount Medicare pays for the health services will not be affected if I do not sign this authorization form;
3. That I may see and copy any information described in this form;
4. That I may copy this Authorization after I sign it, and if I am unable to make a copy, I may request a copy from ExamWorks Clinical Solutions;
5. That this authorization expires upon approval of the Medicare Set-Aside Arrangement by CMS and completion of any other services;
6. That I may revoke this Authorization at any time by written notice to ExamWorks Clinical Solutions, but that any revocation shall have no effect on actions which have been taken by ExamWorks Clinical Solutions prior to receiving my revocation;
7. That any personal medical information that I authorize to disclose may be subject to re-disclosure and no longer protected by law;
8. That I have the right to refuse to sign this authorization.

I have read and understand the contents of this Authorization and have had the opportunity to discuss same with counsel of my choice. The contents of this Authorization confirm, and are consistent with, my authority, instructions, or directions to ExamWorks Clinical Solutions, and I understand that by executing this Authorization, I am authorizing ExamWorks Clinical Solutions, to use and disclose, as permitted and outlined herein, certain nonpublic information.

_____ Date: 2-27-18
Signature of Claimant or ~~Legal~~ Representative

_____
Relationship to Claimant if Legal Representative

(Except for Legal Representatives acting in capacity as a parent to the claimant, a copy of the document giving the Legal Representative the authority to sign this Authorization must be attached.)
**In the case where a minor child is the claimant, the release MUST have the child's SS# on it, but signed by the Parent or Legal Guardian.*