MEDICAL AUTHORIZATION FORM

To: LWP Claims Solutions, Inc.
3835 N. Freeway Blvd., Suite 210
Sacramento, CA 95834

I, ____ hereby authorize the following medical providers (medical provider is defined as any acupuncturist, clinic, chiropractor, physical therapy provider, primary physician, or specialist who has administered medical treatment to me) to disclose their entire medical file and any other protected health information concerning me to LWP CLAIMS SOLUTIONS, INC. and its agents, employees and representatives. The protected health information to be disclosed includes medical records; doctors notes; laboratory records/reports; diagnostic test reports/films; photographs; bill/statement of charges; and, all documentation pertaining to history, examination, diagnosis, condition, etiology, prognosis, treatment and care.

Faculty/Physician Name	Address	City	State	Zip	Phone	First Treatment Date	Last Treatment Date

This authorization also includes disclosure of information on the diagnosis and treatment of:

	Yes	No
Mental illness including psychiatric/psychological treatment	___	___
Alcohol, drugs and tobacco	___	___
HIV infection and sexually transmitted diseases	___	___

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction except those outlined above. This protected health information is to be disclosed under this authorization at my request, as permitted by 164.508©(1)(IV) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to LWP CLAIMS SOLUTIONS, INC. or by sending a written revocation directly to My Providers. I further understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization. I understand that any information disclosed pursuant to this Authorization my be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, LWP CLAIMS SOLUTIONS, INC. agrees to protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policy.

I understand that My Provider may not refuse to provide treatment or payment for health care because I refused to sign this Authorization. I acknowledge that I have received a copy of this Authorization.

_______________________________ Signature

_______________________________ Print Name

____________________ Date

_______________________________ Date of Birth

_______________________________ Social Security Number

This authorization complies with HIPAA Privacy Rule
(Medical Authorization Form 09-04)