CLAIM NUMBER:

Authorization for Use or Disclosure of Protected Health Information

I hereby authorize the use of disclosure of my medical information (also known as protected health information) as described below.

1. I, _____, authorize all persons or entities who provided medical treatment to me for injuries I received on _____ to disclose the following medical information in your possession to Sedgwick Inc., its employees, agents, subcontractors and authorized representatives ("Sedgwick").
2. Please provide Sedgwick with any and all information in your possession concerning my healthcare history, diagnosis, condition, treatment, or evaluation related to injuries I received on _____ so that they may use it or disclose it to evaluate, administer and resolve my claim related to such injuries. I understand that the medical information that is disclosed may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
3. The authorization shall be in force and effect until my claim related to injuries I received on _____ is resolved, at which time this authorization to use or disclose this protected health information expires. I understand that I may revoke this authorization by notifying Sedgwick CMS in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by Sedgwick or the Releasing Party Pin reliance on it before I revoke it.
4. As the person signing this Authorization for Release of Protected Health Information, I understand that I am giving permission to Sedgwick to obtain and Use protected health information. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
5. A copy of this authorization may be accepted with the same authority as the original.

_____ ____/_____/_____ ____-_____-_____

Printed Name of Patient or Personal Representative Date of Birthday SSN

_____ _____

Signature of Patient or Personal Representative Date

The completed form may be uploaded to your claim at www.starrtravelclaims.com or return via email at starrtravelclaims@sedgwick.com

Fax: 614-956-2234

Mail: Starr Travel Claims

PO Box 94645

Cleveland, Ohio 44101-4729

MEDICAL PROVIDER LIST

Patient Name:	CLAIM NUMBER:
1. Name of Facility/Physician:	
Address:	
Type of Provider (hospital, family doctor,specialist, etc.,):	
Phone:	
2. Name of Facility/Physician:	
Address:	
Type of Provider (hospital, family doctor,specialist, etc.,):	
Phone:	
3. Name of Facility/Physician:	
Address:	
Type of Provider (hospital, family doctor,specialist, etc.,):	
Phone:	

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