AUTHORIZATION FOR RELEASE OF NON-PUBLIC PERSONAL HEALTH INFORMATION

I hereby authorize OccuMed of New England to disclose my health information, as described below:

I authorize the release and disclosure of any and all information, documents, files, records, charts, progress notes, diagnoses, and the like, in your possession, custody or control, concerning care, evaluation, diagnosis, treatment, and billing for any such care, evaluation, diagnosis, treatment and billing, pertaining to me, including but not limited to, any and all information concerning matters of a physical, mental, emotional, psychological, and psychiatric nature to OccuMed of New England and companies shown below, and their employees and agents who will perform risk management, claim adjustment or administration (collectively, the Company),

I further authorize such employees and agents of OccuMed to copy and/or reproduce the desired portions of such documents, files, records, chart, progress notes, evaluations, and the like pertaining to such care, evaluation, treatment, and billing. Information obtained pursuant to this Authorization will be used for (purposes of risk management, claim adjustment or administration).

OccuMed of New England will have complete and unrestricted rights to OBTAIN, DISCLOSE, RELEASE, or MAKE USE of the information about me identified above, including medical records, hospitals records, reports, charts, notes, histories, laboratory records and reports, diagnostic test reports, doctors' and nurses' notes, correspondence, and all other material, including x-ray films, MRIs, CTs and EMG/NCS and charges for all care, treatment and prognosis at any and all times for any condition whatsoever.

The persons hereby authorized to RELEASE, and DISCLOSE, this information include, to the extent permitted by law, health care providers, health maintenance organizations, government agencies, other insurance companies, insurance database operators, third-party administrators or managed care companies, their agents or contractors.

The validity of this Authorization is governed by and construed in accordance with the laws of the Commonwealth of Massachusetts, without regard to its conflicts of law provisions.

This Authorization expires 24 months from the date executed, or on the date my claim is concluded, if earlier.

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I understand that a copy of this Authorization will be furnished to me and/or my legal or authorized representative upon request.

I understand that any revocation of this Authorization will be effective only from the date it is received, will not apply retroactively, and will not be effective to the extent OccuMed of New England or any other person has already relied on the Authorization.

I understand that upon my request OccuMed will provide me with information about my privacy rights afforded me by applicable law.

A copy of this Authorization shall be as valid as the original.

I hereby waive any claim, now or in the future, against OccuMed arising out of the disclosure, release, or use of any personal or privileged information about me under the terms of this authorization, including, but not limited to, any claim of a violation of my right to privacy.

(I understand this Authorization may allow the information specified herein to be disclosed to persons or organizations that are not health plans, covered healthcare providers, or healthcare clearinghouses subject to federal privacy laws governing the use and disclosure of personal health information. I understand that the information authorized to be disclosed pursuant to this authorization may be subject to further disclosure by the recipient(s) and no longer protected by federal privacy regulations or other applicable law.

I have read the above and fully understand its contents in its entirety and have asked questions about anything that was not clear to me and am satisfied with the answers I have received.

I understand, also, that by executing this Authorization that it is not a release of a claim for damages.

Signature:_____

Print Name:_____

Signed this_____day of_____, 20_____

***If an authorized legal representative of the claimant executed this Authorized, attach a copy of the authorization.**