AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
PURSUANT TO 45 CFR § 164.508

TO:

I do hereby authorize use and/or disclosure of protected health information maintained on me, to:

Transguard Insurance Company of America, Inc.
P.O. Box 2148
Warrenville, IL 60555
(or such other person Transguard may authorize)

Pursuant to § 164.508C(1)(i), I authorize the disclosure and providing copies of my **entire chart,** which includes but is not limited to the following:

medical records	operative reports	respiratory therapy records
sign-in sheets	admit reports	physical therapy records
x-ray reports/films	consultation reports/notes	speech therapy records
MRI reports/films	physician(s) orders	occupational therapy records
CT reports/films	discharge reports	dietician records
discogram reports/films	doctor's notes/orders	medication/prescription records
bone scan reports/films	nursing notes	S.O.A.P. notes
EMG/nerve conduction reports	entire charts	progress notes
myelogram reports/films	itemized invoices and/or	laboratory reports
other diagnostic test reports/films	billing for services rendered	rehabilitation records
diagnostic records or reports	documentation regarding insurance	cardiac studies records

By placing an "X" in the following box, I am indicating that I DO NOT authorize the release of HIV Test Results. An HIV Test Result is the original document, or copy thereof, transmitted to the medical record from the laboratory or other testing site with the result of an HIV-related test. It does not include any other note, notation, diagnosis, report, or other writing or document. An HIV-related test is a test that is performed solely for the purpose of identifying the presence of antibodies or antigens indicative of infection with Human Immunodeficiency Virus. (This restriction does not apply to the release of HIV test results as otherwise prescribed by law). I DO NOT authorize release of HIV Test Results ☐.

This authorization shall expire upon the resolution of the litigation concerning the injury involving me.

- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health care provider specified herein. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.
- Fees/charges will comply with all laws and regulations applicable to release of information.
- I understand that authorizing the use and/or disclosure of information is voluntary. I do not need to sign this form to ensure healthcare treatment.

A photocopy of this signed authorization shall be as valid and binding as the original.

I have read the above and authorize the disclosure of the protected health information as stated.

_____	_____	_____
Patient Legal Name	Patient Date of Birth	Patient Social Security Number

_____	_____
Signature of Patient/Legal Representative	Date

If signed by legal representative, relationship to patient is: _____