CITY OF HOUSTON FIRE DEPARTMENT - EMERGENCY MEDICAL SERVICES AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Read the instructions on page 3 carefully before completing this form.

This authorization is meant to comply with and satisfy the requirements of the Health Insurance Portability and Accountability Act ("HIPAA"), Title 45, Part 164 of the Code of Federal Regulations and Chapter 773 of the State of Texas Health and Safety Code. Pursuant to these laws, the undersigned states as follows:

Section I. PATIENT INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
SOCIAL SECURITY or OTHER IDENTIFICATION#	DATE OF BIRTH:	

Section II. Voluntary Authorization to Release Medical Services Records

I, ____, voluntarily authorize the City of Houston, its agents,
Patient, Legal Guardian, or Authorized Representative
servants, employees, officials, and attorneys to release, to person listed in Section IV of this form, the following Emergency Medical Service records (i.e., documents, audio and video recordings, etc.), maintained by the City of Houston, for the above-referenced patient for medical services provided on __________________________.
Date of Service

Section III. Description of Information Authorized for Release (***See*** **Instructions on Page 3 to complete this section.)**

a. ❑ Entire Emergency Medical Services Record, except sensitive information described in (e) below.
b. ❑ Only information related to (specify): ______________________________________

____
c. ❑ Only records related to events during the period from ______________to ___________
d. ❑ Other (specify): ____

e. **If you would like any of the following sensitive information disclosed, check the applicable box(es) below:**

❑ Alcohol/Drug Abuse Treatment/Referral
❑ Sexually Transmitted Diseases
❑ HIV/AIDS-related Treatment
❑ Mental Health (Other than Psychotherapy Notes)

Section IV. Name and Address of Person or Organization to Receive Patient's Health Information
(Please Print)

Name: Discovery Resource
Address: 1511 West 34th Street
Houston, Texas 77018

Section V. Purpose for Release *(See attached instructions):*

Please provide the purpose for the use or disclosure:

____
____

Section VI. Expiration Date or Event

Please provide a date or event upon which you wish this authorization to expire:__________________________
____

If you fail to specify an expiration date or event, this authorization will expire one year from the date it was signed. If you choose to specify an expiring event, you must provide the City with an actual date at the time that this authorization is signed or by written notice sent to: City of Houston Fire Department - Emergency Medical Services Records Division located at: 500 Jefferson, Suite# 1600, Houston, Texas 77002. If the City does not receive written notice containing the actual date of expiration, the City will continue to rely on this authorization for one year from the date it was signed.

Section VII. Right to Revoke

I understand that I may revoke or withdraw this authorization, in writing, submitted at any time by submitting a revocation to the City of Houston Fire Department - Emergency Medical Services Records Division located at: 500 Jefferson, Suite# 1600, Houston, Texas 77002, except to the extent that the City of Houston Fire Department has already used or disclosed the requested protected health information in reliance on my authorization.

Section VIII. Permitted Redisclosure

I understand that the information, disclosed under this authorization, is subject to redisclosure by the recipient and is no longer protected health information. I also understand that withdrawal of consent does not affect any information disclosed before the date on which written notice of withdrawal was received.

I understand that authorizing the use or disclosure of the above-identified information is voluntary. I also understand that I do not need to sign this form to ensure health care treatment.

Section IX. Photocopies of Authorization

I agree that a photocopy of this form will have the same effect as the original.

Section X. Charge for Photocopies of Records

I understand that the City of Houston will charge for photocopies of the requested record(s) according to the schedule provided by sections 2-98 and 2-99 of the City of Houston Code of Ordinances.

Section XI. Patient's Right to Refuse Signature and Obtain Copies

I understand I am entitled to inspect or copy the protected health information to be used or disclosed. I understand I have the right to refuse to sign this authorization and I am willing to sign this authorization.

Section XII. Agreement Not to Sue the City for Release Under This Authorization

I agree not to claim damages or sue the city, or any of its employees or elected or appointed officials, for releasing the medical information as authorized by me in this document.

Section XIII. Patient/Authorized Representative's Signature and Date

PLEASE READ THIS ENTIRE FORM, INCLUDING THE INSTRUCTIONS, CAREFULLY BEFORE SIGNING THIS FORM.

SIGNED on this the ____ day of ________________________, 20 _______.

___

SIGNATURE OF PERSON CONSENTING TO THE RELEASE OF HIS OR HER RECORDS OR SIGNATURE AND PRINTED NAME OF AUTHORIZED REPRESENTATIVE

___

PRINTED NAME AND ADDRESS OF THE PERSON CONSENTING TO THE RELEASE OF RECORDS

NOTE: If the person signing this form is an authorized personal representative, please provide a description of such representative=s authority to act for the individual below **and**, if other than a parent of a minor or dependent child, attach a copy of the power of attorney, evidence of guardianship, or other document authorizing representation:
____
____

STATE OF TEXAS §
§
COUNTY OF ____________________ §

BEFORE ME, the undersigned authority, on this day personally appeared ___________________________________, whose identity has been proven to me, and who, after being duly sworn did depose, acknowledge and swear that he/she executed the foregoing **CITY OF HOUSTON FIRE DEPARTMENT - EMERGENCY MEDICAL SERVICES AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION** in his/her capacity as set out above, as his/her free act and deed, and that he/she is over the age of eighteen (18) years and is of sound mind.

GIVEN under my hand and seal of office on this ___ day of _________________, 20 ______.

____
NOTARY PUBLIC IN AND FOR
THE STATE OF TEXAS

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using blue ink.

2. **Section I**, print name, address, social security number, and date of birth of the patient.

3. **Section II**, print the name of the patient or authorized person. Then fill in the date of service.

4. **Section III**, check the appropriate box as applicable.

   a. **Entire Emergency Medical Services Record** - the complete record except for sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).

   b. **Only information related to** – specify diagnosis, injury, operations, special therapies, etc.

   c. **Only the period of events from** - specify date range, e.g., Jan. 1, 2002 to Feb. 1, 2002.

   d. **Other (specify)** - e.g., billing, employee health.

   e. **IN ORDER TO RELEASE SENSITIVE INFORMATION INCLUDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), YOU MUST CHECK THE APPROPRIATE BOX.**

5. **Section IV**, print the name and address of the person or organization to whom your health information should be released. The person or organization authorized to receive your health information should provide you with a copy of the completed Emergency Medical Services Authorization for Release of Protected Health Information.

6. **Section V**, state the reason for release of the medical information, e.g., litigation, disability claim, continuing medical care, etc.

   If this release is for litigation purposes, please include the case name, cause number, county or district, and court number.

7. **Section VI**, if an *expiration* date other than one year from signature is desired, specify an expiration date in the space provided.

   If you fail to specify an expiration date or event, this authorization will expire one year from the date it was signed.

   If you choose to specify an expiring event, you must provide the City with an actual date at the time that this authorization is signed or by written notice sent to: City of Houston Fire Department - Emergency Medical Services Records Division located at: **500 Jefferson, Suite# 1600, Houston, Texas 77002.** If the City does not receive written notice containing the actual date of expiration, the City will continue to rely on this authorization for one year from the date it was signed.

8. **Section XIII**, sign and date in the presence of a notary. An authorized representative must include a description of their authority, i.e. legal guardian, power of attorney, etc.

   If the person signing this form is an authorized personal representative, please provide a description of such representative=s authority to act for the individual below **and**, if other than a parent of a minor or dependent child, attach a copy of the power of attorney, evidence of guardianship, or other document authorizing representation.

AUTHORIZATION FOR DISCLOSURE
RELEASE OF HEALTH INFORMATION/MEDICAL RECORDS

Health Insurance Portability and Accountability Act of 1996
45 CFR Subtitle A, Subchapter C, Part 164.512 (e) (1) (iii)

Identification of patient:

______________________________	______________________________
PATIENT'S NAME	PATIENT'S SOCIAL SECURITY NO.
______________________________	______________________________
PATIENT'S DATE OF BIRTH	FACILITY/PROVIDER TO RELEASE

Dates of service/treatment to be released: ____________________ **to** ____________________

Class of persons authorized to make the disclosure: All physicians and other health care providers who have examined, treated, consulted with, or x-rayed ____________________________ and all hospitals, nursing facilities, rehabilitation facilities, clinics or laboratories in which ____________________________ has been a patient and/or resident.

Description of information to be disclosed: You are hereby authorized and directed by the undersigned to give to the bearer of this authorization, or any photostatic copy thereof, any and all information relative to ___________________________________'s physical, emotional, and mental condition and permit the bearer to examine x-rays, laboratory reports, and medical records of any kind which reflect diagnosis, treatment, prognosis, and any other information concerning illness, injuries, or disability. Such information shall specifically include, but is not limited to, itemized billing records/statements, history & physical, operative reports, lab/pathology reports, consultation reports, physicians' orders, discharge/death summary, x-ray reports/images, other radiographic reports/images, emergency room records, face sheets, nurses' notes, flow sheets, pharmacy and medication records, care plans, assessment tools, screening tools, summaries, social workers, legal, and monitor strips, readouts or printouts. I understand that the specified information to be released may include, but is not limited to: history, diagnosis and/or treatment of drug or alcohol abuse, mental illness, psychological and/or psychiatric treatment, counseling records/notes, genetic testing or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). You are hereby authorized and directed to make available all such information for inspection and copying.

Person or entity to whom information is to be released/disclosed:

or it's agent

Discovery Resource
1511 West 34th Street
Houston, Texas 77018

Purpose of this authorization: At the request of the undersigned individual and for insurance purposes.

Duration of this authorization: This authorization expires one (1) year from the date signed.

Right to Revoke: I understand that I may revoke this authorization in writing at any time by contacting the Release of Information Dept. at ____, except to the extent that action has been taken in reliance upon the authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected.

I understand that I have a right to a copy of this authorization.

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.

A photostatic copy of this authorization shall be considered as valid as the original.

____
DATE SIGNED

____
PRINTED NAME OF PERSON LEGALLY AUTHORIZED TO MAKE RELEASE

____
SIGNATURE OF PERSON LEGALLY AUTHORIZED TO MAKE RELEASE

____
CAPACITY OF PERSON LEGALLY AUTHORIZED TO MAKE RELEASE
(if self state "self")

Form **4506**

(Rev. January 2010)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Request may be rejected if the form is incomplete or illegible.**

OMB No. 1545-0429

Tip. You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return,** or you can call 1-800-829-1040 to order a transcript.

1a Name shown on tax return. If a joint return, enter the name shown first.

1b First social security number on tax return or employer identification number (see instructions)

2a If a joint return, enter spouse's name shown on tax return.

2b Second social security number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

4 Previous address shown on the last return filed if different from line 3

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.

Caution. *If the tax return is being mailed to a third party, ensure that you have filled in line 6 and line 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy.*

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ ____________

Note. *If the copies must be certified for court or administrative proceedings, check here* . . . . ☐

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

____________ ____________ ____________ ____________

____________ ____________ ____________ ____________

8 **Fee.** There is a $57 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.**

a	Cost for each return	$ 57.00
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☐

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note.** *For tax returns being sent to a third party, this form must be received within 120 days of signature date.*

Telephone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) Date

▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's** signature Date

General Instructions

Section references are to the Internal Revenue Code.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate a third party to receive the tax return. See line 5.

How long will it take? It may take up to 60 calendar days for us to process your request.

Tip. Use Form 4506-T, Request for Transcript of Tax Return, to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of non-filing, and record of account.

Automated transcript request. You can call 1-800-829-1040 to order a transcript through the automated self-help system. Follow prompts for "questions about your tax account" to order a tax return transcript.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year and the chart below shows two different RAIVS teams, send your request to the team based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to the "Internal Revenue Service" at:
Florida, Georgia, North Carolina, South Carolina	RAIVS Team P.O. Box 47-421 Stop 91 Doraville, GA 30362
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, or A.P.O. or F.P.O. address	RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alaska, Arizona, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	RAIVS Team Stop 37106 Fresno, CA 93888
Arkansas, Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia	RAIVS Team Stop 6705 P-6 Kansas City, MO 64999

Chart for all other returns

If you lived in or your business was in:	Mail to the "Internal Revenue Service" at:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Utah, Washington, Wyoming, a foreign country, or A.P.O. or F.P.O. address	RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia, Wisconsin	RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250

Specific Instructions

Line 1b. Enter your employer identification number (EIN) if you are requesting a copy of a business return. Otherwise, enter the first social security number (SSN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the return be sent to a third party, the IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the Letters Testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. Sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, and the District of Columbia for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 16 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224. Do not send the form to this address. Instead, see *Where to file* on this page.

Memorial Hermann Healthcare System

Authorization for: ❒ **Disclosure** ❒ **Inspection** ❒ **Amendment**

Of Protected Health Information

Patient Name	Date of Birth	SS#	MR#
Address			Telephone # ( )

I hereby authorize ______________________________

Facility Name

To release information from the medical records of ______________________________

Patient Name

To: Discovery Resource, 1511 West 34th Street, Houston, Texas 77018

Name/Address of person/organization to which disclosure is to be made

Fax # 713-228-3311 Phone # 713-223-3300

For treatment dates: ______________________________

Specify dates - this line **MUST BE** completed

For the following purpose: ❑ Medical Care ❑ Legal ❑ Insurance ❑ Other (detail below)

____

Select Portions

- ❑ Abstract/Pertinent Information
- ❑ Lab
- ❑ Emergency Room
- ❑ Imaging/Radiology
- ❑ Nursing Notes
- ❑ H & P
- ❑ Cardiac Studies
- ❑ MD Progress Notes
- ❑ MD Orders
- ❑ Face Sheet
- ❑ Operative/Procedure Report
- ❑ Entire Record ***EXCLUDING*** - HIV Testing & Chemical Dependency.
- ❑ Entire Record ***INCLUDING*** - HIV Testing & Chemical Dependency.
- ❑ Entire Record ***INCLUDING*** - HIV Testing only.
- ❑ Entire Record ***INCLUDING*** - Chemical Dependency only.
- ❑ Itemized Bill
- ❑ Other ______________________________

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of Memorial Hermann Healthcare System to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

______________ ______________________________ ______________________

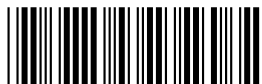
Date **Signature of Patient/Parent/Conservator/Guardian** **Authority/Relationship to**

Fees/charges will comply with all laws and regulations applicable to release of Protected Health Information. Payment is due at time of release.

Memorial Hermann Hospital System

FOR YOUR WHOLE LIFE.™

Release of Protected Health Information



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INSTRUCTION AND INFORMATION SHEET FOR SF 180, REQUEST PERTAINING TO MILITARY RECORDS

1. General Information. The Standard Form 180, Request Pertaining to Military Records (SF180) is used to request information from military records. Certain identifying information is necessary to determine the location of an individual's record of military service. Please try to answer each item on the SF 180. If you do not have and cannot obtain the information for an item, show "NA," meaning the information is "not available." Include as much of the requested information as you can. To determine where to mail this request see Page 2 of the SF180 for record locations and facility addresses.

Online requests may be submitted to the National Personnel Records Center (NPRC) by a veteran or deceased veteran's next of kin using eVetRecs at http://www.archives.gov/veterans/evetrecs/.

2. Personnel records and Service Treatment Records (STR). Personnel records of military members who were discharged, retired, or died in service **less than 62 years** ago and STR's are in the legal custody of the military service department and are administered in accordance with rules issued by the Department of Defense and the Department of Homeland Security (DHS, Coast Guard). STR's of persons on active duty are generally kept at the local servicing clinic, and usually are available from the Department of Veterans Affairs approximately 40 days after the last day of active duty. (See item 3, Archival Records, if the military member was discharged, retired or died in service over 62 years ago.)

a. Release of information: Release of information is subject to restrictions imposed by the military services consistent with Department of Defense regulations and the provisions of the Freedom of Information Act (FOIA) and the Privacy Act of 1974. The service member (either past or present) or the member's legal guardian has access to almost any information contained in that member's own record. An authorization signature, of the service member or the member's legal guardian, is needed in Section III of the SF180. Others requesting information from military personnel records and/or STR's must have the release authorization in Section III of the SF 180 signed by the member or legal guardian. If the appropriate signature cannot be obtained, only limited types of information can be provided. If the former member is deceased, surviving next of kin may, under certain circumstances, be entitled to greater access to a deceased veteran's records than a member of the general public. The next of kin may be any of the following: unremarried surviving spouse, father, mother, son, daughter, sister, or brother. Requesters **must provide proof of death**, such as a copy of a death certificate, letter from funeral home or obituary.

b. Fees for records: There is no charge for most services provided to service members or next of kin of deceased veterans. A nominal fee is charged for certain types of service. In most instances service fees cannot be determined in advance. If your request involves a service fee, you will be notified as soon as that determination is made.

3. Archival Records. Personnel records of military members who were discharged, retired, or died in service **62 or more years** ago have been transferred to the legal custody of NARA and are referred to as "archival" records.

a. Release of Information: Archival records are open to the public. The Privacy Act of 1974 does not apply to archival records, therefore, written authorization from the veteran or next of kin is not required. However, in order to protect the privacy of the veteran, his/her family, and third parties named in the records, the personal privacy exemption of the Freedom of Information Act (5 U.S.C. 552 (b) (6)) may still apply and preclude the release of some information.

b. Fees for Archival Records: Access to archival records is granted by offering copies of the records for a fee (44 U.S.C. 2116 (c)). You will be notified if there is a charge for photocopies of documents contained in the record you are requesting.

4. Where reply may be sent. The reply may be sent to the service member or any other address designated by the service member or other authorized requester.

5. Definitions and abbreviations. DISCHARGED -- the individual has no current military status; SERVICE TREATMENT RECORD (STR) -- The chronology of medical, mental health and dental care received by service members during the course of their military career (does not include records of treatment while hospitalized); TDRL – Temporary Disability Retired List.

6. Service completed before World War I. National Archives Trust Fund (NATF) forms must be used to request these records. Obtain the forms by e-mail from *inquire@nara.gov* or write to the Code 6 address on page 2 of the SF 180.

PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

The following information is provided in accordance with 5 U.S.C. 552a(e)(3) and applies to this form. Authority for collection of the information is 44 U.S.C. 2907, 3101, and 3103, and Public Law 104-134 (April 26, 1996), as amended in title 31, section 7701. Disclosure of the information is voluntary. If the requested information is not provided, it may delay servicing your inquiry because the facility servicing the service member's record may not have all of the information needed to locate it. The purpose of the information on this form is to assist the facility servicing the records (see the address list) in locating the correct military service record(s) or information to answer your inquiry. This form is then retained as a record of disclosure. The form may also be disclosed to Department of Defense components, the Department of Veterans Affairs, the Department of Homeland Security (DHS, U.S. Coast Guard), or the National Archives and Records Administration when the original custodian of the military health and personnel records transfers all or part of those records to that agency. If the service member was a member of the National Guard, the form may also be disclosed to the Adjutant General of the appropriate state, District of Columbia, or Puerto Rico, where he or she served.

PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

Public burden reporting for this collection of information is estimated to be five minutes per request, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to National Archives and Records Administration (NHP), 8601 Adelphi Road, College Park, MD 20740-6001. DO NOT SEND COMPLETED FORMS TO THIS ADDRESS. SEND COMPLETED FORMS AS INDICATED IN THE ADDRESS LIST ON PAGE 2 OF THE SF 180.

Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 10/31/2011

REQUEST PERTAINING TO MILITARY RECORDS

* Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/evetrecs/ *

(To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. Please print clearly or type.)

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much as possible.)

1. NAME USED DURING SERVICE (last, first, and middle)	**2.** SOCIAL SECURITY NO.	**3.** DATE OF BIRTH	**4.** PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that all service be shown below.)

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE COMPONENT						
b. RESERVE COMPONENT						
c. NATIONAL GUARD						

6. IS THIS PERSON DECEASED? If "YES" enter the date of death.
☐ NO ☐ YES ______________________

7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE?
☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU WOULD LIKE TO REQUEST A COPY OF:

☐ **DD Form 214 or equivalent.** This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. NOTE: If more than one period of service was performed, even in the same branch, there may be more than one DD214. **Check the appropriate box below to specify a deleted or undeleted copy**. When was the DD Form(s) 214 issued? YEAR(S):

☐ **UNDELETED:** Ordinarily required to determine eligibility for benefits. Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.

☐ **DELETED:** The following items are deleted: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and for separations after June 30, 1979, character of separation and dates of time lost.

☐ **All Documents in Official Military Personnel File (OMPF)**

☐ **Medical Records** (Includes Service Treatment Records (outpatient), inpatient and dental records.) If hospitalized, the facility name and date for each admission **must** be provided:

☐ **Other** (Specify):

2. PURPOSE: (An explanation of the purpose of the request is **strictly voluntary**; however, such information may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.) Check appropriate box:

☐ Benefits ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Medals/Awards ☐ Genealogy ☐ Correction ☐ Personal
☐ Other, explain:

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER IS: (*Signature Required in # 3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.)*

☐ Military service member or veteran identified in Section I, above
☐ Next of kin of deceased veteran **(Must provide proof of death)**.
Show relationship: ______________________
(See item 2a on accompanying instructions.)

☐ Legal guardian (Must submit copy of court appointment.)
☐ Other (specify) ______________________

2. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

Name

Street Apt.

City State Zip Code

3. AUTHORIZATION SIGNATURE REQUIRED *(See items 2a or 3a on accompanying instructions.)* I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct.

Signature Required - Do not print

Date of this request ( ) Daytime phone

Email address

*This form is available at *http://www.archives.gov/research/order/standard-form-180.pdf* on the National Archives and Records Administration (NARA) web site.*

Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 10/31/2011

LOCATION OF MILITARY RECORDS

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

BRANCH	CURRENT STATUS OF SERVICE MEMBER	ADDRESS CODE	
		Personnel Record	Service Treatment Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired on or after 10/1/2004	1	11
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, retired reserve in nonpay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	13	
COAST GUARD	Discharge , deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired on or after 4/1/1998	14	11
	Active, reserve, or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1905	6	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired on or after 1/1/1999	4	11
	Individual Ready Reserve	5	
	Active, Selected Marine Corps Reserve, TDRL	4	
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	14
	Discharged, deceased, or retired after 10/16/1992	14	11
	Active enlisted, officers (including National Guard and Army Reserve on active duty in the U.S. Army)	7	
	National Guard enlisted and officers not on active duty in Army	13	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired on or after 1/1/1995	10	11
	Active, reserve, or TDRL	10	
PHS	Public Health Service - Commissioned Corps officers only	12	

ADDRESS LIST OF CUSTODIANS (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

Code	Address	Code	Address	Code	Address
1	**Air Force Personnel Center HQ AFPC/DPSSRP 550 C Street West, Suite 19 Randolph AFB, TX 78150-4721**	6	**National Archives & Records Administration Old Military and Civil Records (NWCTB-Military) Textual Services Division 700 Pennsylvania Ave., N.W. Washington, DC 20408-0001**	11	**Department of Veterans Affairs Records Management Center P.O. Box 5020 St. Louis, MO 63115-5020**
2	**Air Reserve Personnel Center /DSMR HQ ARPC/DPSSA/B 6760 E. Irvington Place, Suite 4600 Denver, CO 80280-4600**	7	**U.S. Army Human Resources Command *www.hrc.army.mil***	12	**Division of Commissioned Corps Officer Support ATTN: Records Officer 1101 Wooton Parkway, Plaza Level, Suite 100 Rockville, MD 20852**
3	**Commander, CGPC-adm-3 USCG Personnel Command 4200 Wilson Blvd., Suite 1100 Arlington, VA 22203-1804**	8	***Reserved.***	13	**The Adjutant General (of the appropriate state, DC, or Puerto Rico)**
4	**Headquarters U.S. Marine Corps Personnel Management Support Branch (MMSB-10) 2008 Elliot Road Quantico, VA 22134-5030**	9	***Reserved.***	14	**National Personnel Records Center (Military Personnel Records) 9700 Page Ave. St. Louis, MO 63132-5100 *e*VetRecs! *www.archives.gov/veterans/evetrecs/***
5	**Marine Forces Reserve 4400 Dauphine St. New Orleans, LA 70146-5400**	10	**Navy Personnel Command (PERS-312E) 5720 Integrity Drive Millington, TN 38055-3120**		

AUTHORIZATION FOR THE RELEASE OF

PERSONNELL / PAYROLL RECORDS

Employees Name	Date of Birth	Social Security #	
Address		Telephone	

I hereby authorize ____
(Company Name)

To release information from the employment/payroll/workers comp. records of:

____
Employee

To: Discovery Resource, 1511 West 34th Street, Houston, Texas 77018
Name/address of person/organization to which disclosure is to be made

Fax # 713-228-3311 Phone #: 713-223-3300

For the following purpose:

____

____

I specifically authorize the release of the following:

_____ Employment application

_____ Payroll/salary records

_____ Letters of Commendation/Discipline

_____ Performance evaluations

_____ Vacation use records

_____ Other: *(Specify)* ______________________________

_____ All Records in the departmental personnel file

This authorization is valid until the 180th day after it is signed, unless it provides otherwise, not to exceed 24 months, or unless it is revoked.

I, the undersigned, have read and authorize the release of such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used to disclose pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damages resulting from the lawful release of my protected health information.

_______________ ______________________________
Date Signature of Employee

Quest diagnostics Incorporated

PATIENT AUTHORIZATION
TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I authorize Quest Diagnostics to use and/or disclose protected health information (which may pertain to my diagnosis and treatment , laboratory test results, medical history, billing information, ordering and treating physicians and other related information, including but not limited to HIV and drug testing information) as specifically identified in the original subpoena attached to this authorization and to the person(s) named in the subpoena (Photocopies, facsimile transmissions, and similar non-original versions of the subpoena are unacceptable). This authorization will expire when Quest Diagnostics has provided the required information.

I understand that the following employees of Quest Diagnostics are authorized to use and/or disclose my PHI (in accordance with this Authorization): employees in Client Services, Billing Services, Legal and Compliance, Operations, Medical, and Human Resources. I authorize attorney(s) and their legal staff and/or Court clerks as required by the subpoena attached to this authorization to receive my PHI.

I understand that my PHI will be used and/or disclosed for the purpose(s) indicated on the attached subpoena. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law

---

Notice to the patient:
If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services to you on the receipt of this signed Authorization except if you are participating in a research project;
- You may request a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization;
- We must provide you with a copy of the signed authorization; and
- This authorization only covers PHI that is disclosed by Quest Diagnostics The information could be redisclosed by the person(s) who receive it and, in that case your PHI will not be protected by the HIPAA privacy and security rules;
- You have the right to revoke this Authorization at any time, provided that you do so in writing, except to the extent that we have already relied on this Authorization to use or disclose your information.

Patient's Information (#1-3 are required):

1. Patient's Name: ____________ ____________ ____________ 2. Date of Birth: ____________
First Name Middle Name Last Name (MM/DD/YYYY)

3. Social Security Number: ____________ OR 3. Ordering Physician's Name (or practice name): ____________

In addition to the above three items, any ADDITIONAL TWO items must be provided:

4. Gender o Male o Female

5. Patient's Address:
Street: ____________
City: ____________ State: ______ ZIP: ______

6. Social Security Number (unless provided above): ____________

7. Insurance ID# ____________

8. QD patient invoice statement number: ____________

9. Ordering physician's name (or practice name): ____________

10. Ordering physician's address: ____________

11. Ordering physician's phone number: ____________

Signature:
I have reviewed and I understand this Authorization.

Name (print) ____________

Signed: ____________ Date: ____________
(Patient)

Or By: ____________ Date: ____________
(Patient's Representative)

Description or Representative's Authority ____________
This Authorization will expire on: ____________ (or) after the following event: ____________
(MM/DD/YYYY)

Please send the requested information to the following:
Discovery Resource
1511 West 34th Street
Houston, Texas 77018
Phone: 713-223-3300
Fax: 713-228-3311

Quest diagnostics Incorporated

Patient Revocation (to be signed only if you wish to revoke the Authorization, except to the extent that we have already relied on this Authorization to use or disclose your information)

I hereby revoke this authorization to use and/or disclose my protected health information. This revocation is effective on the date that it is signed below, and Quest Diagnostics may not use or disclose my protected health information that is subject to this authorization after this date. I understand that if Quest Diagnostics has previously relied upon this authorization to use and/or disclose my PHI that such previous use and or disclosure may not be revoked.

Signed: ______________________________ Date: ______________________

For Internal Use Only:

Quest Diagnostics Incorporated
Los Angeles
7600 Tyrone Avenue
Van Nuys, CA 91405

Form Approved
OMB No. 0960-0566

Social Security Administration

Consent for Release of Information

Please read these instructions carefully before completing this form.

When to Use This Form

Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor, or an insurance company).

Natural or adoptive parents or a legal guardian, acting on behalf of a minor, who want us to release the minor's:
- **nonmedical** records, should use this form.
- medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F4. You can get this form at any Social Security office.

How to Complete This Form

This consent form must be completed and signed only by:
- the person to whom the information or record applies, or
- the parent or legal guardian of a minor to whom the **nonmedical** information applies, or
- the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:
- Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.
- Fill in the name and address of the individual or group to which we will send the information.
- Fill in the reason you are requesting the information.
- Check the type(s) of information you want us to release.
- Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

PAPERWORK REDUCTION ACT: Paperwork Reduction Act Statement: This information collection meets the clearance requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. The office is listed under U. S. Government agencies in your telephone directory or you may call 1-800-772-1213 for the address. You may send comments on our estimate of the time needed to complete the form to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

Form Approved
OMB No. 0960-0566

Social Security Administration

Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
Discovery Resource	1511 West 34th Street, Houston, TX 77018

I want this information released because:

____

(There may be a charge for releasing information.)

Please release the following information:

_____ Social Security Number
_____ Identifying information (includes date and place of birth, parents' names)
_____ Monthly Social Security benefit amount
_____ Monthly Supplemental Security Income payment amount
_____ Information about benefits/payments I received from __________ to __________
_____ Information about my Medicare claim/coverage from __________ to __________
(specify) ______________________________
_____ Medical records
_____ Record(s) from my file (specify) ______________________________
_____ Other (specify) ______________________________

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: ______________________________
(Show signatures, names, and addresses of two people if signed by mark.)

Date: ______________ Relationship: ______________

Form Approved
OMB No. 0960-0525

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. **Certified/Non-Certified Detailed Earnings Information**

   Includes periods of employment or self-employment and the names and addresses of employers.

   OR

2. **Certified Yearly Totals of Earnings**

   Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM FOR:

Non-certified yearly totals of earnings

This service is free to the public.

These totals can be obtained by calling 1-800-772-1213 to receive Form SSA-7004, Request for Social Security Statement

PRIVACY ACT NOTICE: We are authorized to collect this information under section 205 of the Social Security Act, and the Federal Records Act of 1950 (64 Stat. 583). It is needed so we can identify your records and prepare the statement you request. You do not have to furnish the information, but failure to do so may prevent your request from being processed.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 11 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

INFORMATION ABOUT YOUR REQUEST

- **How Do I Get This Information?**

  You need to complete the attached form to tell us what information you want.

- **Can I Get This Information For Someone Else?**

  Yes, if you have their written permission. For more information, see page 3.

- **Who Can Sign On Behalf Of The Individual?**

  The parent of a minor child, or the legal guardian of an individual who has been declared legally incompetent, may sign if he/she is acting on behalf of the individual.

- **Is There A Fee For This Information?**

1. **Certified/Non-Certified Detailed Earnings Information**

   Yes, we usually charge a fee for detailed information. In most cases, this information is used for purposes NOT directly related to Social Security such as for a private pension plan or personal injury suit. The fee chart on page 3 gives the amount of the charge.

   Sometimes, there is no charge for detailed information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us and it does not agree with your records), we will supply you with more detail for the period in question. Occasionally, earnings amounts are wrong because an employer did not correctly report earnings or earnings are credited to the wrong person. In situations like these, we will send you detailed information, at no charge, so we can correct your record.

   Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

   We will certify the detailed earnings information for an additional fee of $15.00. Certification is usually not necessary unless you plan to use the information in court.

2. **Certified Yearly Totals of Earnings**

   Yes, there is a fee of $15 to certify yearly totals of earnings. Certification is usually not necessary unless you plan to use the information in court.

3. **Method of Payment**

   Enclose a check or money order for the entire fee required. Payment can also be made by credit card. To do so, complete page 4 of this form and return it with your request form.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?

   Print the Name, Social Security Number (SSN), and date of birth below.

   Name ______________________ Social Security Number ______________________

   Other Name(s) Used (Include Maiden Name) ______________________ Date of Birth (Mo/Day/Yr) ______________________

2. What kind of information do you need?

   ☐ **Detailed Earnings Information** (If you check this block, tell us below why you need this information.) For the period(s)/year(s): ______________________

   ____

   ____

   ☐ **Certified Yearly Totals of Earnings (Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Social Security Statement)** **For the year(s):** ______________________

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 . . . . A. $ ______________________

   Do you want us to certify the information? ☐ Yes ☐ No

   If yes, enter $15.00 . . . . B. $ ______________________

   ADD the amounts on lines A and B, and enter the TOTAL amount . . . . C. $ ______________________

   - You can pay by CREDIT CARD by completing and returning the form on page 4, or
   - Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payble to "Social Security Administration"
   - DO NOT SEND CASH.

4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5,000 or one year in prison.

   SIGN your name here (Do not print) > ______________________ Date ______________________

   Daytime Phone Number ________ ______________
   (Area Code) (Telephone Number)

5. Tell us where you want the information sent. (Please print)

   Name Discovery Resource Address 1511 West 34th Street

   City, State & Zip Code Houston, Texas 77018

6. Mail Completed Form(s) To:

   Social Security Administration
   Division of Earnings Record Operations
   P.O. Box 33003
   Baltimore, Maryland 21290-3003

   Exception: If using private contractor (e.g., FedEx) to mail form(s), use:

   Social Security Administration
   Division of Earnings Record Operations
   300 N. Greene St.
   Baltimore, Maryland 21290-0300

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

How Much Do I Have to Pay For Detailed Earnings?

1. Count the number of years for which you need detailed earnings information. Be sure to add in both the first and last year requested. However, do not add in the current calendar year since this information is not yet available.

2. Use the chart below to determine the correct fee.

Number of Years Requested	Fee	Number of Years Requested	Fee	Number of Years Requested	Fee
1	$15.00	15	$43.75	28	$64.50
2	17.50	16	45.50	29	66.00
3	20.00	17	47.25	30	67.50
4	22.50	18	49.00	31	68.75
5	25.00	19	50.75	32	70.00
6	27.00	20	52.50	33	71.25
7	29.00	21	54.00	34	72.50
8	31.00	22	55.50	35	73.75
9	33.00	23	57.00	36	75.00
10	35.00	24	58.50	37	76.25
11	36.75	25	60.00	38	77.50
12	38.50	26	61.50	39	78.75
13	40.25	27	63.00	40	80.00
14	42.00				

For Requests Over 40 Years, Please Add 1 Dollar for Each Additional Year.

- **Whose Earnings Can Be Requested**

1. Your Earnings

You can request earnings information from your own record by completing the attached form; we need your handwritten signature. If you sign with an "X", your mark must be witnessed by two disinterested persons who must sign their name and address.

2. Someone Else's Earnings

You can request earnings information from the record of someone else if that person tells us in writing to give the information to you. This writing or "authorization" must be presented to us within 60 days of the date it was signed by that person.

3. A Deceased Person's Earnings

You can request earnings information from the record of a deceased person if you are the legal representative of the estate, a survivor (that is, the spouse, parent, child, divorced spouse of divorced parent), or an individual with a material interest (example-financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

Proof of death must be included with your request. Proof of appointment as representative or proof of your relationship to the deceased must also be included.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit card rules will apply. You may also pay by check or money order.

Please fill in all the information below and return this form along with your request to:

Social Security Administration
Division of Earnings Record Operations
P.O. Box 33003
Baltimore, Maryland 21290-3003

Exception:
If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration
Division of Earnings Record Operations
300 N. Greene St.
Baltimore, Maryland 21290-0300

Note: Please read Paperwork/Privacy Act Notice

CHECK ONE →	☐ Visa ☐ American Express ☐ MasterCard ☐ Discover ☐ Diners Card
Credit Card Holder's Name → (Enter the name from the credit card)	______________ First Name, Middle Initial, Last Name
Credit Card Holder's Address →	______________ Number & Street ______________ City, State, & Zip Code
Daytime Telephone Number →	______ ______________ Area Code Telephone Number
Credit Card Number →	______ -- ______ -- ______ -- ______
Credit Card Expiration Date →	______ ______ Month Year
Amount Charged →	$ ______________
Credit Card Holder's Signature →	

DO NOT WRITE IN THIS SPACE OFFICE USE ONLY	Authorization	
	Name	Date
	Remittance Control #	

PRIVACY ACT NOTICE

The Social Security Administration (SSA) has authority to collect the information requested on this form under section 205 of the Social Security Act. Giving us this information is voluntary. You do not have to do it. We will need this information only if you choose to make payment by credit card. You do not need to fill out this form if you choose another means of payment (for example, by check or money order).

If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and SSA's account. We may also provide this information to another person or government agency to comply with federal laws requiring the release of information from our records. You can find these and other routine uses of information provided to SSA listed in the Federal Register. If you want more information about this, you may call or write any Social Security Office.

STATEMENT OF ASSURANCE FOR SUBPOENAS
INDIVIDUAL NOTIFICATION FOR SUBPOENA OF PROTECTED HEALTH INFORMATION

To Whom It May Concern:

To comply with federal regulations protecting patient privacy [Health Insurance Portability and Accountability Act of 1996, 45CFR Subtitle A, Subchapter C, Part 164.512(e)], we must obtain satisfactory assurance from the party issuing the below-named subpoena that notice has been provided to the patient whose protected health information has been subpoenaed. Please note that only the attorney issuing the subpoena may sign this form. We cannot respond to the enclosed subpoena until this form is completed, signed and returned (along with the subpoena) to the address listed below.

Name of the Court for Proceeding	**Docket Number Date Issued**
Name of the Plaintiff	**Name of Defendant**
Name of the Patient	**Hospital Name**
Hospital Medical Records Number	**Patient Account Number**
Date(s) of Service	

ATTORNEY CERTIFCATION

As the attorney issuing the above subpoena, I hereby certify that the following statements are true and have attached hereto documentation demonstrating that each of these facts is true:

(1) I have made a good faith attempt to provide written notice to the above-named patient, either directly or through the patient's retained counsel,____

___________________________of ____

that his/her protected health information has been subpoenaed.

(2) The notice I provided included sufficient information about the litigation or proceeding for which the protected health information is requested to permit the patient to raise an objection to the court or administrative tribunal.

(3) The time for the patient to raise objections to the court or administrative tribunal has elapsed, and (CHECK ONE)

_____ No objections were filed; or

_____ All objections filed by the patient were resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.

_________________________________ ________________

Signature of Attorney Issuing Subpoena Date

____

Printed Name of Attorney Issuing Subpoena

Sworn to and Subscribed Before Me on this ________ day of the ______________, 20______.

____

Notary Public in and for the state of Texas

My commission Expires______________________________

TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
7551 Metro Center Drive, Suite 100
Austin, TX 78744

SUBMIT A SEPARATE DWC FORM-153 FOR EACH DWC OR IAB #

REQUEST FOR COPIES OF CONFIDENTIAL CLAIMANT INFORMATION

Please carefully read the information on both sides of this form and the accompanying Instructions. INCORRECTLY COMPLETED FORMS WILL BE RETURNED TO REQUESTOR WITHOUT ACTION. This form must be signed by a party eligible to receive the information requested. Additional documentation may be required for eligibility. The signature must be notarized.

(Please type or print)

I. CLAIM FILE IDENTIFICATION. Provide the following information to identify the requested claim file.

DWC or IAB Number		Employee's Social Security Number	-- --
Employee's Name		Employee's Date of Injury	-- --
Last First MI			m m d d y y y y
Address City		State	Zip Code

II. REQUESTOR INFORMATION. Provide the following information pertaining to the requestor.

Name		DWC/Representative Box No. (If Applicable):	
Address		E-mail Address:	
City, State	ZIP	Telephone No. ( )	Fax No. ( )

III. INFORMATION REQUESTED. Please indicate the information and services requested. Service consists of paper copies of claim information maintained in paper and/or electronic format within the following areas of the Division of Workers' Compensation files.

☐ Claim File ☐ Certified ☐ Uncertified

- ☐ Dispute Resolution Contact Data (electronic)
- ☐ Complete File
- ☐ Specific Document in File:________________________

☐ Medical Dispute Resolution File (after 1/1/91) ☐ Certified ☐ Uncertified
Tracking No: ____________________

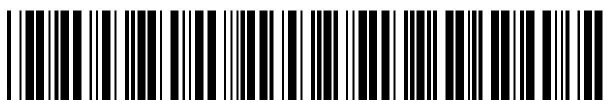
- ☐ Medical Dispute Resolution Contact Data (electronic)
- ☐ Complete File
- ☐ Specific Document in File:________________________

☐ Indemnity Dispute Resolution File (claims with a date of injury after 1/1/91 only). ☐ Certified ☐ Uncertified
DWC Docket No: ___________________

- ☐ Complete File
- ☐ Specific Document in File:________________________
- ☐ Video Tape (if available) ☐ CD (if available) ☐ Audio Tape (if available)
- ☐ Tape Transcription: Hourly Rate

Any questions about a specific file should be directed to the area maintaining the file.

ALL PAGES MUST BE COMPLETED



IMPORTANT: BY EXECUTING THIS FORM, REQUESTOR REPRESENTS THAT HE OR SHE IS ENTITLED TO THE INFORMATION REQUESTED AND HAS FULL AUTHORITY TO ACT AS A REQUESTOR. REQUESTOR ALSO ACKNOWLEDGES LIABILITY FOR PAYMENT OF ALL AMOUNTS OWED FOR SERVICES PROVIDED AS A RESULT OF THIS REQUEST.

IV. REQUESTOR ELIGIBILITY AND NOTARIZATION. (PLEASE CHECK ONE BOX ONLY)

The Texas Workers' Compensation Act, Texas Labor Code, Title 5, Section 402.084, limits the release of confidential information in or derived from a claim file to the categories of persons listed below. Indicate the category of eligibility, which qualifies you to receive the information requested. Sign and complete the notarization prior to sending the request to the Texas Department of Insurance (TDI) Division of Workers' Compensation (DWC). Eligibility will be verified by TDI DWC.

] The employee or the employee's legal beneficiary (ATTACH DOCUMENTATION)

] The employee's or the legal beneficiary's representative (ATTACH DOCUMENTATION)

] The employer at the time of injury. Requestor must provide injured employee's period of employment: (ATTACH DOCUMENTATION)

_______ to _______
mo./yr mo./yr.

] The Texas Certified Self-Insurer Guaranty Association Established under Subchapter G, Chapter 407, if that association has assumed the obligations of an impaired employer.

☐ The insurance carrier or insurance carrier's legal counsel/representative. (ATTACH DOCUMENTATION)

☐ The Texas Property and Casualty Insurance Guaranty Association, if that association has assumed the obligations of an impaired insurance company

☐ A third party litigant in a lawsuit, in which the cause of action arises from the incident that gave rise to the injury. (COPY OF PETITION AND ANSWER MUST BE ATTACHED). Requestor must provide injured employee's date of injury _______
mo/yr

☐ Health Care Provider who is a party to a Medical Dispute (Section 413.031 of the Act)

I have read and understand this form and the accompanying instructions. **I am entitled** to receive the confidential employee information being requested as indicated above. **I understand** that it is a Class A misdemeanor to unlawfully receive, publish, disclose, or distribute confidential information in or derived from an employee's claim file. [Texas Labor Code, Sections 402.064; 402.081; 402.083 - .084; 402.086 and 402.091]

Name of Requestor: ____________________
(Please Print)

Position/Title: ____________________

Firm Name: ____________________
(if applicable)

Federal Tax I.D.#: ____________________

Signature: ____________________ ____________
Date

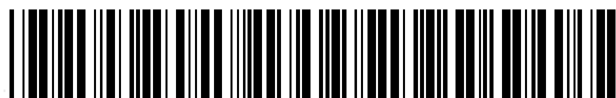
State of ____________________ *
*
County of ____________________ *

Before me on the above date personally appeared ____________________,
who after first being sworn or affirmed, said that the statements contained in this request are true.

Signed ____________________

Notary Public, State of ____________________

My Commission Expires ____________________

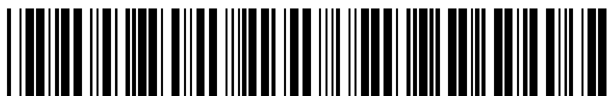


REQUEST FOR COPIES OF CONFIDENTIAL CLAIMANT INFORMATION INSTRUCTIONS (DWC FORM-153)

1. **DWC FORM-153 MUST BE COMPLETED IN ITS ENTIRETY.** Please print or type. Submit a separate DWC FORM- 153 request form for each DWC claim number for which you are requesting copies. **We do not accept faxed or emailed copies.** We do not release claimant information except as provided by law.
2. Section II (Requestor Information) includes a space for an e-mail address. The e-mail address is requested so that TDI may process the request expeditiously, obtain additional information to complete verification and for billing purposes. The e-mail address is made confidential under TEX. GOV'T CODE ANN. § 552.137 and will not be released without your affirmative consent.
3. A requestor MUST indicate in Section IV the legal basis on which he/she is **eligible** to receive requested confidential employee information. Only individuals in the categories listed are entitled to receive copies of confidential information. See, Texas Workers' Compensation Act, Texas Labor Code, Section 402.084. See TDI's website for additional information. Additional documentation required for eligibility.
   - A. An eligible insurance carrier must have handled a workers' compensation claim for the injured worker.
   - B. An out of state insurance carrier or employer, or their legal representative, may be eligible to receive confidential claim file information. Documentation of a workers' compensation claim against that employer or the insurance carrier paying that claim must be provided to determine eligibility.
4. A lay person or a legal representative may represent a claimant or a claimant beneficiary. Other parties eligible to receive confidential claim file information may authorize a legal representative to request and receive the information on their behalf. To establish eligibility to receive confidential claim file information, the legal representative of a party must provide documentation of representation, e.g. letter of representation from client, copy of the contract between the client and the representative or the defendant's original answer.
5. The requestor must swear or affirm to the correctness of the entitlement information before a **notary public**, sign the completed form before the notary, and have the notary complete the acknowledgment. The original signed and notarized form should be mailed or personally delivered to the address indicated at top of DWC FORM-153. Incorrectly attested forms will be returned without action.
6. **Copies of this form** will be accepted if **both** sides are an exact reproduction of the original and include an original signature and notarization.
7. Indicate if a **certified copy** is requested. The copy of the information requested will have a letter of certification attached, which is signed or stamped and sealed by the Custodian of Records, or their delegate, attesting to the authenticity of the attached document(s). See Section III. Certifications are an additional $1.00 fee each.
8. **Charges and billing will be as follows:**
   - A. **Charges exceeding $40 will require approval and estimates over $100 will require a deposit before documents can be provided/mailed. TDI Agency Counsel will send an itemized statement after the documents are mailed. Questions regarding billing should be directed to TDI Agency Counsel.**
   - B. Make checks payable to the Texas Department of Insurance.
9. No priority mailing is available unless the requestor provides an account number.
10. For **additional assistance** in completing this form call the area that maintains the file requested. Records Center file call (512) 804-4990 x354 or x355; Medical Dispute Resolution file call (512) 804-4812; Indemnity Dispute Resolution file call (512) 804-4060.
11. A cancellation of a request must be in writing, call the TDI Agency Counsel section at (512) 475-1757 or one of the above-listed areas. Cancellation will **NOT** relieve requestor of responsibility for payment of amounts owed for services provided PRIOR to notice of cancellation. Any questions regarding billing should be directed to TDI Agency Counsel at (512) 463-6434.

GOVERNMENTAL AGENCIES/POLITICAL SUBDIVISIONS OR REGULATORY BODIES requesting copies of confidential claimant information in a capacity other than as an employer, should not complete this form. Please contact DWC Legal Services at (512) 804-4275 for information concerning determination of eligibility to receive confidential information.

IMPORTANT: BY EXECUTION OF DWC FORM-153, THE REQUESTOR REPRESENTS THAT HE OR SHE IS ENTITLED TO THE INFORMATION REQUESTED AND THAT HE OR SHE HAS FULL AUTHORITY TO ACT AS A REQUESTOR. IT IS A CLASS A MISDEMEANOR FOR UNAUTHORIZED PERSONS TO RECEIVE CONFIDENTIAL CLAIM FILE INFORMATION OR TO DISCLOSE SUCH INFORMATION TO UNAUTHORIZED PERSONS (TEXAS LABOR CODE §§ 402.064; 402.081; 402.083 - .084; 402.086 & 402.091). THE REQUESTOR ALSO ACKNOWLEDGES LIABILITY FOR PAYMENT OF ALL AMOUNTS OWED FOR SERVICES PROVIDED AS A RESULT OF THIS REQUEST.



Send to:
TEXAS WORKERS' COMPENSATION COMMISSION
7551 Metro Center Drive, Suite100 , MS-92B
Austin, TX 78744

REQUEST FOR RECORD CHECK

INSTRUCTIONS: Please carefully read the instructions before completing this form. INCORRECT/INCOMPLETE FORMS WILL BE RETURNED TO REQUESTOR WITHOUT ACTION. PAYMENT MUST ACCOMPANY REQUEST FORM.

I. CLAIMANT IDENTITY. Provide the following information to identify the injured employee

Injured Employee's Name	Injured Employee's Social Security Number

II. REQUESTOR INFORMATION. Record check information will be sent to the requestor's address shown below.

Requestor		Title	
Firm Name		TWCC/Adjuster Box Number (if applicable)	
Mailing Address		TWCC Account Number (if applicable)	
City, State	ZIP	Telephone Number ( )	☐ Authorized Legal Representative Statement on File

III. FEES.

Record Checks are $15.00 each. ☐ Check box if Certification is requested. ($1 Additional Fee)

IV. REQUESTOR ELIGIBILITY AND NOTARIZATION. The Texas Workers' Compensation Act, Texas Labor Code, Title 5, Section 402.084, limits the release of confidential information in or derived from an employee's claim file to the categories of parties listed below. Please indicate the category of eligibility, which qualifies you to receive the information requested. Sign and complete the notarization prior to sending the request to TWCC. Eligibility will be verified. *Please check one box only.*

☐ The employee or the employee's legal beneficiary

☐ The employee's or the legal beneficiary's representative (attach letter of representation)

☐ The employer at the time of injury. Requestor must provide injured employee's period of employment:

______ to ______
mo./yr. mo./yr.

☐ The Texas Certified Self-Insurer Guaranty Association established under Subchapter G, Chapter 407, if that association has assumed the obligations of an impaired employer

☐ The workers' compensation insurance carrier. Requestor must provide injured employee's date of injury: ______
mo./dy./yr.

☐ The Texas Property and Casualty Insurance Guaranty Association, if that association has assumed the obligations of an impaired insurance company

☐ A third party litigant in a lawsuit, in which the cause of action arises from the incident that gave rise to the injury (COPY OF PETITION AND ANSWER MUST BE ATTACHED). Requestor must provide injured employee's date of injury:

______
mo./yr.

I have read and understood this form and the accompanying instructions. I am entitled to receive the confidential employee information being requested as indicated above. I understand it is a Class A misdemeanor to unlawfully receive, publish, disclose, or distribute confidential claim information in or derived from an employee's claim file. {Texas Labor Code, Sections 402.064; 402.084; 402.086; 402.091}

Signature of Requestor ______________________ Date __________

State of ______________________ *
*
County of ______________________ *

Before me on the above date personally appeared, ______________________ ,
who after first being sworn, said the statements contained in this request are true.

Signed ______________________

Notary Public, State of ______________ My Commission Expires __________

FORM TWCC-155
REQUEST FOR RECORD CHECK INSTRUCTIONS
www.twcc.state.tx.us

1. Use this form (TWCC-155) to request a history on a Texas workers' compensation claim. A record check provides the following data: the Industrial Accident Board (IAB) or Texas Workers' Compensation Commission (TWCC) number; the date of injury; the employer at the time of injury; the nature of the injury; and the disposition of the claim (old law) or whether the claim is Income/Indemnity or Reportable (new law). **NOTE**: Injuries prior to 1/1/91 are IAB/old law. Injuries on or after 1/1/91 are TWCC/new law.

2. **THIS FORM TWCC-155 MUST BE COMPLETED IN ITS ENTIRETY**. Please print or type. Send a separate TWCC-155 request form for each claimant for which you are requesting a record check. The original TWCC-155 must be submitted to the Commission.

3. **PAYMENT MUST ACCOMPANY THIS REQUEST FORM. THE REQUEST WILL BE RETURNED IF PAYMENT IS NOT ENCLOSED. FEES ARE SUBJECT TO CHANGE.**
   A. All record checks are $15.00 each.
   B. Certifications are $1.00 additional fee each. If a certified record check is requested, the record check response will have a letter of certification attached which is signed or stamped and sealed by the Custodian of Records, or his delegate, attesting to the authenticity of the attached document. See Section III.

4. The requestor **MUST** indicate the legal basis on which he or she is **eligible** to receive confidential claimant information. Check **only one** category in Section IV that reflects your eligibility to receive confidential information.
   A. An eligible insurance carrier must have handled a workers' compensation claim for the injured worker.
   B. An out of state insurance carrier or employer, or their legal representative, may be eligible to receive record check information. Documentation of a worker's compensation claim against that employer or the insurance carrier paying that claim must be provided to determine eligibility (also see number 5 below).
   C. Dates of employment or date of injury must be indicated if applicable.

5. A party eligible to receive record check information may authorize a legal representative to request and receive the information on their behalf. If legal representative is requestor, box must be checked for verification purposes. Refer to TWCC Advisory 95-01 for requirements and additional information. To obtain a copy of this advisory visit the TWCC website indicated above. To establish eligibility to receive confidential information, the legal representative of a party must provide documentation of representation, e.g. letter of representation from client, copy of the contract between the client and the representative or Original Answer.

6. The requestor **MUST** swear to the correctness of the entitlement information before a **notary public,** sign the completed form before the notary, and have the notary complete the sworn acknowledgment. The original signed and notarized form should be mailed or personally delivered to the address indicated at top of form TWCC-155. Incorrectly attested forms will be returned to the requestor without action.

7. Cancellation of a request for a record check may be made by calling the Reprographics Section/Record Checks at (512) 804-4990 ext. 319. **No refunds will be made after the request has been processed.**

8. For additional assistance in completing this TWCC-155, or to make an inquiry regarding the status of your request, call the Reprographics Section/Record Checks at (512) 804-4990 ext. 319.

9. FAX requests and/or altered forms will **not** be accepted.

10. To obtain **copies of confidential claim files** complete and file Request For Copies Of Confidential Claimant Information Form (TWCC-153). To obtain a **pre-employment check** on persons who have been given a tentative offer of employment, complete and file Prospective Employment Authorization and Certification Form (TWCC-156).

11. Governmental Agencies/Political Subdivisions or regulatory bodies requesting confidential claimant information in a capacity other than as an employer, should not complete this form. Please contact TWCC General Counsel at (512) 804-4275 for information concerning determination of eligibility to receive record check information.

IMPORTANT: BY EXECUTION OF FORM TWCC-155, THE REQUESTOR REPRESENTS THAT HE OR SHE IS ENTITLED TO THE INFORMATION REQUESTED AND THAT HE OR SHE HAS FULL AUTHORITY TO ACT AS A REQUESTOR. IT IS A *CLASS A MISDEMEANOR* FOR UNAUTHORIZED PERSONS TO RECEIVE CONFIDENTIAL CLAIM FILE INFORMATION OR TO DISCLOSE SUCH INFORMATION TO UNAUTHORIZED PARTIES. TEXAS LABOR CODE §§ 402.064; 402.084; 402.086 & 402.091.

AUTHORIZATION TO RELEASE CONFIDENTIAL UNEMPLOYMENT INSURANCE RECORDS

I ____,

Social Security Number: _________________________________,

authorize the Texas Workforce Commission to release the following records (please check applicable items):

_____ Unemployment Insurance claims records

_____ Wage Record

_____ Other (please list) ____

____

to the following person/entity:

Discovery Resource, 1511 West 34th Street, Houston, Texas 77018

I understand that these are the records of a state agency, and I expressly authorize that that agency to release these records to the above person/entity for the following purpose:

____

____

I authorize the release of records for use only for the purpose listed above. Any person(s) obtaining records pursuant to this Authorization shall be solely responsible for the payment of all costs assessed by the Texas Workforce Commission for providing such records. A legible photocopy or telecopy transmission facsimile of this Authorization shall be deemed equivalent to the original. This Authorization shall be valid for a period of six months from the date if execution set forth below, or until my written revocation is received by TWC, whichever occurs earlier.

This release shall apply to all time periods of records held or maintained by TWC unless specifically limited herein.

Date: _________________________________

Signature: ____

Printed Name: ____

Mail to TWC Open Records, 101 East 15th Street, Room 266, Austin, Texas 78778-0001

Authorization to Release Private Health Information

Legal

HIPAA Team

702 SW 8th Street
Bentonville, AR 72716-0215
Phone 479.273.4505
Fax 479.204.9655
rxlegal@walmartlegal.com

Section 1: Patient Information

Patient Name:			Date of Birth:
Address:			
City:	State:	Zip:	Phone:

Section 2: Requestor and Purpose **(If to be released to patient check here ☐ and continue with Section 3)**

Individual or Entity: **Discovery Resource**		Person Receiving Information:	
Address: **1511 West 34th Street**			
City: **Houston**	State: **Texas**	Zip: **77018**	Phone: **(713) 223-3300**
Purpose of Release: ☐ Patient Request	☐ Legal/Attorney Letter	☐ Insurance	☐ Housing

Section 3: Information to be Released (Check All That Apply)

I authorize Walmart to release of the following health information:
☐ Medical Expenses Summary (List of all prescriptions with expense information)
☐ Designated Record Set (Entire medical record maintained by the pharmacy)
☐ Specific Prescription(s): ____________________
☐ One Line Summary (total number of prescriptions and out-of-pocket expenses)

For the following dates of service:
☐ All dates of service ☐ From ____________________ to ____________________

From the following facilities:
☐ All locations where I have had prescriptions filled
☐ Only the following location(s) (include city and state): ____________________

Section 4: Expiration Date or Event

This authorization will remain in effect
☐ Until the following date: ____________________
☐ Until the following event occurs: ____________________
☐ Until one year from the date of my signature below.

Section 5: Understandings

(a) I understand that signing this authorization is voluntary. Receipt of pharmacy services will not be conditioned upon my authorization of this disclosure. (45 C.F.R. 164.508(c)(2)(ii))

(b) I understand that if I authorize the release of my health information to a recipient who is not legally required to keep it confidential, the information may be redisclosed and may no longer be protected by federal or state privacy laws. (45 C.F.R. 164.508(c)(2)(iii))

(c) I have the right to revoke this authorization in writing at any time by notifying the Walmart Legal Department. The revocation will not apply to the extent that (i) Walmart has already released health information based on this authorization or (ii) this authorization was obtained as a condition to the patient obtaining insurance or for an insurer to contest a claim. (45 C.F.R. 164.508(c)(2)(i))

(d) I understand that by signing below I authorize the release of records that may include: HIV/AIDS related information and or records; Mental Health Information and or records; Drug/Alcohol Diagnosis and Treatment Information; Pregnancy and Family Planning Information; Sexually Transmitted Disease Information.

Section 6: Signature and Date

____________________ ____________________
Signature of Patient or Personal Representative Date

If you have signed this as a legally authorized representative of the patient, please print your name and relationship to the patient below. If your relationship is anything other than parent of a minor, please include documentation of your authority to sign for the patient's records.

____________________ ____________________
Name of Personal Representative (please print) **Relationship to Patient (parent, guardian, etc.)**

Walmart
Save money. Live better.

Legal

HIPAA Team

Certification of Satisfactory Assurances

As required by the *Standards for Privacy of Individually Identifiable Health Information ("Privacy Regulations")* promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") this certification provides satisfactory assurances that appropriate steps have been taken to notify and/or otherwise protect the privacy of the individual who is the subject of the protected health information that is being requested.

______Notice

In compliance with 45 C.F.R. § 164.512(e)(1), I hereby certify that I have made a good faith attempt to provide written notice to ____________________________ (the "individual"), whose protected health information I am requesting, (or if the individual's location is unknown, to mail a notice to the individual's last known address at

---

A copy of such written notice is attached to this Certification.

I certify that the notice included sufficient information about the litigation or proceeding in which the protected health information is requested to permit the individual to raise an objection to the court or the administrative tribunal. Further, I certify that the time for the individual to raise objections to the court or administrative tribunal has elapsed and wither, (1) no objections were filed; or (2) all objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.

OR

_____ Qualified Protective Order

In compliance with 45 C.F.R. § 164.512(e)(1), I hereby certify that:

_____ the parties to the dispute giving rise to this request for information have agreed to a qualified protective order and have presented it to the court or administrative tribunal with jurisdiction over the dispute.

OR

_____ I requested a qualified protective order from the court or administrative tribunal on ____________.

A copy of the qualified protective order or my request for such is attached to this Certification

---

____________________________________	____
Name	**Date**
____________________________________	____
Signature	**Company or Law Firm**