JOHNS EASTERN COMPANY, INC.

Claims Adjusters &
Third Party Administrators

Special Account Services PO Box 110279, Lakewood Ranch, FL 34211
Tel: (941) 907-3100 Fax: (941) 527-4040 Toll Free: 1-800-749-3044

Employer: **Indian River County Board of County Commissioners**

Employee: DOB:

Address SSN: (last 4 digits)

Date of Accident Claim #

INFORMATION TO BE RELEASED FROM:

Name of Facility or Provider	Address & Phone

INFORMATION TO BE RELEASED TO:

Johns Eastern Company and/or legal counsel for Johns Eastern Company
P.O. Box 110279, Lakewood Ranch, FL 34211 -- Phone: 1-800-749-3044

INFORMATION TO BE RELEASED (Check all that apply)
___ Any and all medical records for all dates of service including but not limited to medical reports/notes; lab reports/results; pathology reports/results; radiology reports/results, operative reports, therapy records, progress notes, discharge summary, history and physical, etc.
___ X-rays/Scans (films or CDs) ___ Pharmacy records

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE
The patient has an active Workers Compensation Claim

PATIENT AUTHORIZATION:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released.
*EXCLUDE the following information from the records released (please initial)

___ Drug/Alcohol abuse/treatment & diagnosis ___ Sexually transmitted disease
___ HIV/AIDS diagnosis/treatment/testing ___ Mental Illness or psychiatric diagnosis/treatment

MY RIGHTS:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information that I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time in may no longer be protected under Privacy laws. **THIS RELEASE EXPIRES ONE (1) YEAR FROM THE DATE SIGNED.**

***** FRAUD STATEMENT *****
Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in S.817.234.

Employee Signature ____________________ Date ____________

Print Employee Name ____________________ Date of Birth ____________

FLORIDA MARYLAND NORTH CAROLINA PENNSYLVANIA VIRGINIA WASHINGTON, DC