WCSIF Program Benefits Release Form

County Risk Services, Inc.

Third Party Administrator for ACCA Self-Insurers Fund

<u>If you desire program benefits, read and sign below. Benefits will not be authorized without your signature.</u>

I hereby authorize any physician, health care professional, hospital, or other medical care facility to provide my complete health care records to representatives of ACCA WCSIF (Association of County Commissions of Alabama Workers' Compensation Self-Insurers Fund) and/or its agents regarding my health and any treatment rendered. I authorize representatives of ACCA WCSIF and/or its agents to examine any and all records including but not limited to: all history and physical examinations; progress notes; physicians' notes; lab reports; x-ray, MRI, CT scans, myelograms and all other diagnostic procedure reports; all consultation reports and records; in-patient and out-patient facility records; operative reports; payment records; prescribed medications; and all notes, correspondence and records of any kind.

In addition, I authorize the release of information relating to (1) communicable diseases such as hepatitis and the human immunodeficiency virus (HIV); (2) substance abuse treatment records; and (3) all mental health treatment records.

The purpose for disclosure of these records is to allow ACCA WCSIF to evaluate my medical history and injuries in this claim and to administer benefits I may be eligible for under the ACCA WCSIF program. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original. This "Authorization for Release of Health Information" is valid for one year from the date of my signature.

I understand that I may revoke this authorization by sending a signed, written notice to ACCA WCSIF and to the healthcare provider(s) authorized to disclose my health information pursuant to this document. However, I also understand that any revocation will be effective only to the extent that action has not already been taken in reliance of this authorization.

By refusing to sign or revoking this authorization, I understand that ACCA WCSIF will be unable to provide benefits under this program as medical records are required.

Employee Signature:_____ Date: _____