STATE OF ALABAMA

Public Education Employee Injury Compensation Board

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize any physician, hospital, clinic, healthcare provider, pharmacy, laboratory, rehabilitation provider, therapist, employer, insurance carrier, governmental agency, or any other public or private person or entity possessing records concerning my injury, illness, or medical treatment to release such records and information to:
Public Education Employees Injury Compensation Board
c/o Millennium Risk Managers, LLC

This authorization includes all medical, hospital, therapy, pharmacy, diagnostic imaging, laboratory, billing, psychological, psychiatric, vocational, rehabilitation, and other records reasonably related to my injury, illness, medical condition, treatment, or claim.

The information may be used by the Public Education Employees Injury Compensation Board, Millennium Risk Managers, LLC, its employees, agents, attorneys, consultants, nurse case managers, medical review vendors, bill review vendors, utilization review organizations, excess insurance carriers, reinsurers, and other entities involved in administering my on-the-job injury claim for claim investigation, medical management, benefit determination, payment of benefits, litigation, settlement, and other lawful claim administration purposes.

This authorization is intended to comply with the Health Insurance Portability and Accountability Act (HIPAA) and applicable federal and state law. I understand that I may revoke this authorization at any time by providing written notice; however, any revocation shall not affect information previously released in accordance with this authorization.

Unless revoked earlier, this authorization shall remain effective until final resolution of my on-the-job injury claim, including all appeals, or five (5) years from the date signed below, unless otherwise provided by law.

A photocopy, scanned copy, faxed copy, or electronic copy of this authorization shall be considered as valid as the original. I authorize the release of the requested information and release any person or entity providing such information in good faith from liability for doing so as permitted by law.

I certify that I have read and understand this authorization and voluntarily sign it.

CLAIM INFORMATION
Claimant Name: _____
Date of Birth: _____
Last Four Digits of SSN: _____
Employer: _____
Date of Injury: _____
Claim Number: _____

SIGNATURE
Claimant Signature: _____
Printed Name: _____
Date: _____

Please submit to:
Millennium Risk Managers
c/o PEEICB
P.O. Box 382408
Birmingham, AL 35238
Email: PEEICB@mrm-llc.com
Fax: 205-777-6097