AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, do hereby authorize _____ (medical provider) to release unto any representative of FFVA Mutual all medical records of every nature pertinent in any way to any medical treatment rendered on my behalf, including, but not limited to, the following:

1. All office notes, progress reports and summaries;
2. Clinical records;
3. Results of all laboratory tests, including x-rays;
4. Records of prescribed medications and treatments;
5. Telephone logs;
6. Correspondence; and
7. Invoices.

I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. I understand that such information is confidential and is protected by federal law, regardless by signing this release I allow the production of these records to the requesting party. I acknowledge the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

Charges for copies of all records furnished shall be billed to FFVA Mutual, P. O. Box 945927, Maitland, FL 32794-5927**.** A photocopy of the original of this Authorization for Release of Medical Records shall be sufficient and acceptable to all persons and entities from whom these records are requested.

The purpose for the requested disclosure is at the request of the undersigned individual, and this Authorization shall be deemed to comply with all notice requirements of HIPAA, specifically 45 CFR §164.508.

This Authorization shall expire upon final resolution of the action pending with the North Carolina Industrial Commission entitled _____ File No. _____. I understand that I may revoke this Authorization at any time by sending written notice to _____ (medical provider) and to FFVA Mutual.

_____	_____	_____
Date of Birth	Social Security Number	Signature

_____

Date