P.O. Box 1380
Ridgeland, MS 39158-1380
(601) 853-4949
(800) 264-8085
Fax: (601) 853-2727

Authorization for Release of Health Information

Name:	**Social Security #:**
Address:	
Employer Name: Alcorn State University	**AmFed Claim #:**

Personal Health Information to Be Disclosed:
My complete medical file, including but not limited to: doctors' and nurses' notes, x-ray reports and films, lab reports, history and physicals, admission and discharge summaries, physical therapy notes/reports, consultation and operative reports, admission sheets, blood alcohol test results, drug screening test results, histories and profiles, psychiatric records, prescription records, computer data or compilations or reports, itemized bills, psychotherapy notes, physician assistants' notes, diagnostic test results, ambulance reports, patient questionnaires, and all other forms of documents pertaining to each and every admission, emergency room, treatment, and clinic visit of the undersigned.

Purpose of the Disclosure: To investigate and determine workers' compensation benefits, and to perform treatment, payment and health care operations.

Right to Revoke: I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. To revoke authorization, I will contact AmFed Companies, LLC at the address above.

Signature: I _____, have had full opportunity to read and consider the contents of the authorization, and I confirm that the contents are consistent with my direction. I understand this authorization is voluntary. I understand that I am entitled to receive a copy of this authorization after I sign it. I understand that the information disclosed may be subject to redisclosure by the recipient and no longer protected. I hereby give my permission to disclose my personal health information in the manner described herein to my employer, **AmFed Companies, LLC**, their agents, employees, or attorneys. I hereby agree that a copy of this authorization form shall have the same force and effect as the original thereof and further agree that this authorization shall remain valid so long as my claim against my above named employer is pending.

Signature: _____ Date: _____

Witness: _____

If a personal representative on behalf of the individual signs this authorization, complete the following:
Personal Representative's Name: _____
Relationship to Individual: _____