UNISOURCE
DISCOVERY™
DIGITAL DOCUMENT RETRIEVAL

AUTHORIZATION FOR THE RELEASE OF INFORMATION

RECORDS TO BE RELEASED TO **UNISOURCE DISCOVERY** AND
______________________________HEREAFTER KNOWN AS THE CLIENT.

ClAIM/FILE: ____________________________________
NAME: ____________________________________
DATE OF BIRTH ____________________________________
DOL/ DOI: ____________________________________

I hereby authorize (medical providers listed below):

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To release the following information:

Any and all documents and medical records pertaining to the examination, care, diagnosis, and treatment of the patient, including but not limited to all office, emergency room, inpatient and outpatient charts and records nurse's notes, patient questionnaires, operation reports, radiological reports, color photographs, physical therapy and rehabilitation records including all descriptions of exercises prescribed; any and all records regarding prescriptions , including the type of medication, date prescription was filled, doctor who wrote the prescription, instructions on taking the medication, and dosage; and any other information available regarding the prescription(s); sign-in sheets, and documentation which indicate date(s) and time(s) of patient's appointments; all films, including X-Rays, MRI's, CT and CAT scan raw data, imaging studies and diagnostic studies; medical bills, medical billing records, liens, explanation of benefits statements, correspondence relating to billing, records showing write-offs of amounts billed, and records of payment by insurance carriers, governmental entities and/or any other person or entity; regardless of date.

This information is required for evaluation of an insurance claim. I further authorize **Unisource Discovery, Inc.**, a private company and/ **Client** to obtain a copy of such records as are needed for the above stated purpose on behalf of **Client** and/or its agents.

I have read the above and also have been advised of my right to receive a true copy of this authorization. Further, I understand the contents of this written authorization.

in its entirety and have asked questions about anything that was not clear to me, and am satisfied with the answers I have received.

I further acknowledge that I understand my right to revoke this authorization by presenting written notice to **Client**, or **Unisource Discovery**, whom I have authorized to obtain specified records, I further understand that if **Client**, or **Unisource Discovery**, or its agents, has already served the authorization to the entity listed above, they have to right to dishonor my request to revoke the authorization. I understand that granting this authorization is not a condition of receiving any treatment or any payments.

It should be further noted that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

A PHOTOSTAT OR FACSIMILE OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

This authorization shall remain valid for two years from the below date.

Authorizing Signature:

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Printed Name:

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Date:

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THE BELOW ADDITIONAL SIGNATURE IS FOR RELEASE OF SENSITIVE HEALTH INFORMATION CONATIAINING DRUG, ALCOHOL AND PSYCHIATRIC HEALTH INFORMATION:

Additional Signature for Sensitive Information to be Released:

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Date:

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