Reset Form

EMPLOYEE'S AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
State Form 50107 (R5 / 9 - 24)

STATE OF INDIANA
State Personnel Department Benefits Division
Disability Program

Mail completed form to:

JWF Specialty Co, Inc (Third Party Administrator)
PO Box 40968
Indianapolis, IN 46240-0968
Telephone: (888) 818-7795
Fax: (866) 893-4674

AUTHORIZATION FOR RELEASE OF INFORMATION

Employee Name:	
Date of Birth:	
Address:	
Last 4 Digits of SS #	

You are hereby authorized and directed to permit, for claim resolution, short-term disability purposes, the examination of, and the copying and reproduction in any manner, whether mechanical, photographic, or otherwise, for JWF Specialty, CO., Inc.

You are hereby authorized to release any and all medical/claim records and reports concerning medical history, physical condition, consultation, diagnosis, treatment and/or prognosis, including x-ray and other diagnostic reports, laboratory records and reports, all testing of any type and character and reports thereof, hospitalization, pharmacy records and statements of charges.

It is understood that the information in this health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

You are hereby authorized to release any and all data listed above except the following:

It is understood that this authorization may be revoked in writing at any time. The revocation will not apply to information already been released in response to this authorization. This authorization is valid for sixty (60) days. I understand that authorizing the disclosure of health information is voluntary and that any disclosure of information carries the potential of re-disclosure not protected by federal confidentiality rules.

A photocopy of this authorization shall have the same force and effect as the original.

Signature of Patient or Legal Representative	Date

Printed Name

Relationship to Patient