AmTrust North America
An AmTrust Financial Company

Authorization for Release of Medical Information

Provide Signed Form to:
Amtrust North America | AmTrustClaims@amtrustgroup.com |Fax: 678-258-8579

Patient Name _____ DOB: _____
Patient Address: _____
Claim Number: _____

I hereby authorize the use or disclosure of my individually identifiable health/medical information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations.
I authorize the release of information from all medical sources, including: hospitals, clinics, labs, physicians, psychologists, psychiatrists, mental health care providers or facilities, correctional facilities, additional treatment providers or facilities, VA health care facilities, school doctors, nurses and counselors, records administrators, social workers, social security administrators, rehab consultants or counselors, managed care consultants or counselors, vocational consultants or counselors, employers and other insurance carriers and/or their representatives.

Information to be released: **Entire Record**

I understand that my records may contain reference to or results of HIV (AIDS) testing, testing or treatment of communicable diseases, treatment for mental health problems, alcohol history or substance abuse, and I authorize the release of such information to the indicated party, unless specifically prohibited in my instructions above.

Purpose of Disclosure: **At the Request of the individual or his/her legal representative**

I understand that my health care provider shall not condition my treatment, payment, enrollment in health plan or eligibility for benefits on whether I provide authorization for a requested disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to AmTrust North America representative identified above. I understand that a revocation is not effective to the extent that action has already been taken in reliance on the authorization.
I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

Expiration Date: This authorization to disclose this protected health information is valid until the final resolution of the insurance claim in relation to which this authorization is granted or for 24 months from the date of signature, whichever comes first, at which time this authorization will expire.

I understand that a photocopy of this authorization shall have the same force and effect as the original document.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Legal Representative's Authority or Relationship to Patient Daytime Phone | Patient / Representative