North Bay Schools
Insurance Authority

AUTHORIZATION TO USE OR DISCLOSE PROTECTED INFORMATION – HIPAA –

Claimant/Applicant	*Birth Date*	*SS#*

RELEASE FROM	SAID PROVIDER/FACILITY *Name of Person, Company or Organization*	
RELEASE TO	RSP & Associates – 27450 Ynez Rd., Ste 300, Temecula, CA 92591	
	Phone (800)660-1107	Fax (800)660-6322
AGENTS FOR	North Bay Schools Insurance Authority *Name of Person, Company or Organization*	
	380A Chadbourne Road *Address*	Fairfield, CA 94534 *City, State, Zip*
	(707)428-1830 *Phone*	(707)428-1848 *Fax*

The following information is to be disclosed: (Please Check)

- ☒ Any and All Medical Records
- ☐ History and Physical Examinations
- ☐ Consultation and Progress Notes
- ☐ Insurance or Claim Records
- ☐ Physician Reports
- ☐ Laboratory Tests
- ☐ Discharge Summary
- ☐ MRI, X-Rays, Film
- ☐ Radiology Reports
- ☐ Employment, Payroll, Educational or Job Training
- ☐ Police, Arrest, Prison or Probation Records
- ☐ Any and All Records to Include Claims/Billing or Payment Notices for Reimbursement of Any Medical Services Provided Under the Claimant's Health Care Plan
- ☐ Other Medical Records or Health Information here Specified: _____
  _____

Sensitive Information: I understand that this may include information relating to:

(Check to Authorize Release)

- ☐ Acquired Immune Deficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)

☐ Behavioral Health Services, Psychiatric Care, Mental Health Treatment
☐ Sexually Transmitted Disease
☐ Diagnosis/Treatment for Alcohol and/or Drug Abuse
☐ Information for Research Purposes

Services Provided on (Dates): _____

Purpose of this Request:

☒ Discovery for Workers Compensation Claim
☐ Other:

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I understand that my refusal to authorize disclosure of my personal medical information will have no effect on my enrollment/eligibility for benefits, or the amount said provider pays for the health services I receive.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise cancelled, I understand that this authorization will be valid for the duration of the claim as provided in CIC 791.06 (G)2(B).

Other Rights: I understand that authorizing the disclosure of this information is voluntary. I understand that I may inspect or obtain a copy of this authorization or of the information to be used or disclosed, as provided in CFR 164.524.
Notice of the covered entity's ability or inability to condition treatment, payment, enrollment, or eligibility for benefits on the Authorization, including research-related treatment, and, if applicable, consequences of refusing to sign the Authorization. * (see Privacy Rule, 45 C.F.R. 164.508(c)(2))

A PHOTOCOPY OF THIS SIGNED AUTHORIZATION WILL BE DEEMED AS EFFECTIVE AS THE ORIGINAL.

I hereby authorize use or disclosure of the named individual's information as described above.

_____ _____
Signature of Claimant/Applicant or Personal Representative *Date*

_____
If signed by Representative, Relationship to Claimant/Applicant

Medical/Employment History Questionnaire

Your Employer's Workers' Compensation Insurance Carrier has retained the services of **RSP & Associates** to assist in the discovery process of your injury. We are required to obtain information concerning your previous medical history as well as previous employer information and prior workers compensation awards and settlements. Failure to disclose this information may affect your entitlement to future benefits.

Please identify the medical providers, addresses and phone numbers of the physicians that have treated you for this injury, ***as well as your primary care provider and any previous injuries you may have sustained over the last (10) years***. Also include the names, addresses and phone numbers of any previous Employers you have had in the last (10) years.

Physician/Hospital Name:	Phone:
Address:	
Injuries:	
Physician/Hospital Name:	Phone:
Address:	
Injuries:	
Physician/Hospital Name:	Phone:
Address:	
Injuries:	
Physician/Hospital Name:	Phone:
Address:	
Injuries:	
Physician/Hospital Name:	Phone:
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Physician/Hospital Name:	Phone:
Address:	
Injuries:	

Physician/Hospital Name:	Phone:
Address:	
Injuries:	
Physician/Hospital Name:	Phone:
Address:	
Injuries:	

Employer Name:	Phone:
Address:	
Employer Name:	Phone:
Address:	
Employer Name:	Phone:
Address:	
Employer Name:	Phone:
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Employer Name:	Phone:
Address:	
Employer Name:	Phone:
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Employer Name:	Phone:
Address:	
Employer Name:	Phone:
Address:	
Employer Name:	Phone:
Address:	

Signature: _____ Date: _____