

Claim No. _____ DATE _____

HIPAA COMPLIANT AUTHORIZATION

List below the names and addresses of all persons (Doctors, Dentists, Hospitals, Nurses, Funeral Directors, etc.) who rendered, or who are rendering services in connection with injuries sustained in this accident.

NAME AND ADDRESS

To Whom It May Concern

For purposes of evaluating a claim made by me, or on my behalf, and/or for preparing for, conducting, and/or participating in any mediation, arbitration, hearing, trial, or other proceeding associated with my claim, you are hereby authorized to furnish to Government Employees Insurance Company, GEICO General Insurance Company, GEICO Indemnity Company, GEICO Casualty Company, or any of its representatives (individually and collectively referred to as "GEICO") any and all medical information which may be requested concerning my physical and/or mental condition and treatment (excluding "psychotherapy notes" as defined in 45 CFR 164.501) to include, diagnosis, prognosis, and any and all records, files, or other documentation concerning the treatment, prescription, consultation or other advisory visits or events (collectively referred to as the "Records") that pertain to:

- PATIENT: _____
[PATIENT: PRINT YOUR NAME ABOVE]
- DOB: _____
[PATIENT: WRITE YOUR BIRTH DATE ABOVE]
- SSN: _____
[PATIENT: WRITE YOUR SOCIAL SECURITY NUMBER ABOVE]
- The Records shall specifically include, but shall not be limited to, such condition and treatment as may pertain to the automobile accident /loss /claim of _____, 20 ____.
[PATIENT: WRITE DATE OF THE AUTOMOBILE ACCIDENT/LOSS/CLAIM ABOVE]

The information covered by this HIPAA Compliant Authorization includes, but is not limited to, reports, records, test results, X-rays, and any other diagnostic testing and films, billing records (including all insurance files and billing information), all employment records, Worker's Compensation documents and scholastic records/files/documents, whether in your possession or available to you. I understand that the information in the Records may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, behavioral health care/psychiatric care (excluding "psychotherapy notes" as defined in 45 CFR

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164.501), and treatment for alcohol and/or drug abuse, and/or substance abuse. Copies of this Authorization shall be considered as valid as the original. This is not a release of claims for damages. I further understand that I am entitled to a copy of this Authorization and acknowledge receipt by signing below. I acknowledge that the information disclosed pursuant to this Authorization may be re-disclosed by GEICO pursuant to applicable law and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA). I also authorize GEICO to further re-disclose the records received pursuant to this authorization, including, but not limited to, information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, behavioral health care/psychiatric care (excluding "psychotherapy notes" as defined in 45 CFR 164.501), and treatment for alcohol and/or drug abuse, and/or substance abuse, as may be necessary for the purpose of evaluating a claim made by me, or on my behalf, and/or for preparing for, conducting, and/or participating in any mediation, arbitration, hearing, trial, or other proceeding associated with my claim. This HIPAA Compliant Authorization shall also allow GEICO's representatives, agents, consultants, or health care professionals, or any physicians appointed by it, to examine the records produced concerning said condition or treatment.

Revocation Section: I acknowledge that I have the right to revoke this Authorization at any time. A revocation of this Authorization must be in writing and sent via regular U.S. mail, postage prepaid, to the Company Representative who requested this authorization and to the medical provider. The revocation of this Authorization will be effective upon receipt and will be prospective only.

This HIPAA Compliant Authorization will expire _____.
(month) (day) (year)

I acknowledge that I am aware that the consequences of my not signing this Authorization can include a delay in the processing/resolution of the claim, a potential denial of the claim, or other consequences recognized by applicable state law and/or the insurance policy at issue.

[SIGNATURE OF PATIENT]

[PRINT NAME OF PATIENT]

[DATE] _____

Personal Representative's Section: A personal representative executing this form on behalf of the patient warrants that he or she has authority to sign this form on the basis of:

_____.

(SIGNATURE: PERSONAL REPRESENTATIVE)

(PRINT NAME OF PERSONAL REPRESENTATIVE)

(DATE) _____

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.