Instructions

The HIPAA Compliant Authorization gives GEICO permission to obtain medical records and other documentation describing your medical care and how those services are related to your injury. This form is essential to begin reviewing your claim. To complete this form properly, provide the requested information and remember to sign and date the form.

(Form Below)

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 and the amount of bills, if known.

NAME AND ADDRESS AMOUNT OF BILL

_____

_____

_____

_____

_____

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") NY PIP, PO Box 9107, Macon, GA, 31208-9107, Fax Number 856-294-5154 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: PRINT YOUR NAME ABOVE]
- DOB: _____,
  [PATIENT: WRITE YOUR BIRTH DATE ABOVE]
- SSN:_____.
  [PATIENT: WRITE YOUR SOCIAL SECURITY NUMBER ABOVE]
- The Records covered by this HIPAA Compliant Authorization cover the time period beginning five (5) years prior to the date of last treatment through ***[PATIENT: INDICATE YOUR LAST DATE OF TREATMENT IN THE FOLLOWING SPACE]*** _____, 20_____, the date of last treatment, and up to and including the date of Provider's compliance with this HIPAA Compliant Authorization.
- 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 ***[PATIENT: INDICATE THE DATE OF THE AUTOMOBILE ACCIDENT/LOSS/CLAIM IN THE FOLLOWING SPACE]*** _____, 20_____.

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, 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 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 information is being requested 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,

Claim No. _____ **DATE _____**

arbitration, hearing, trial, or other proceeding associated with my claim. This Authorization shall be valid for the period of twenty-four months from the date signed. 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.

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.

New York law requires the following to appear on this form:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

_____ _____

[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)