AUTHORIZATION FOR USE and DISCLOSURE OF PSYCHIATRIC NOTES

I hereby authorize the Health Care Provider(s) named below to disclose to Rockwood Casualty Insurance Company psychiatric notes relating to me for the purposes set forth below, and to permit Rockwood Casualty Insurance Company to obtain and review such information.

Name of Patient: _____

Date of Accident: _____

Name of Health Care Provider(s) authorized to make the disclosure:

_____

_____

_____

Specific description of health information to be disclosed:

> Psychiatric notes with respect to an accident that occurred on the date stated above, including notes recorded (in any medium) documenting or analyzing the contents of conversations during a private counseling session with Patient or a group, joint or family counseling session involving Patient.

Dates of health information to be disclosed: Date of accident through duration of treatment and such prior relevant information that we may request.

Purposes of the use or disclosure: Determining (1) my eligibility for and amounts of workers' compensation insurance benefits, and (2) payments to my health care provider for services rendered.

I hereby authorize Rockwood Casualty Insurance Company to obtain, use, examine, analyze and disclose the psychiatric notes obtained from the Health Care Provider(s) identified above, for the purposes stated above.

Continued on next page

The patient must read and initial the following statements:

a. I understand that this Authorization is being obtained as a condition of obtaining workers' compensation insurance benefits, and that benefits may be challenged or denied if an Authorization for the disclosure of the requested health information is not obtained by .

Initials: _____

b. I understand that this Authorization is not required in order for the Health Care Provider to render health care to the patient, or to seek payment for such services.

Initials: _____

c. I understand that this Authorization will expire upon the final payment or resolution of my workers' compensation claim.

Initials: _____

d. I understand that I may revoke this Authorization at any time by notifying the Health Care Provider in writing, but if I do, it will not affect any actions taken before such person received the revocation, and it may affect my eligibility for workers' compensation benefits.

Initials: _____

e. I understand that the information may be redisclosed by for the purposes stated above, as required or permitted by law.

Initials: _____

f. I intend for a copy of this Authorization to be as effective and valid as the original.

Initials: _____

g. The disclosure of notes and the permission to use the notes obtained pursuant this Authorization shall apply to Rockwood Casualty Insurance Company and to its designated representative(s).

Initials: _____

_____ _____

Signature of Patient/Claimant **Date**