

Appendix C

Page 1 of 2  
Claim Number: [REDACTED]



GALLAGHER BASSETT SERVICES, INC.  
AUTHORIZATION FOR RELEASE OF INFORMATION  
(HIPAA COMPLIANT)

Patient Information:

[REDACTED]	BD: [REDACTED]	SS# [REDACTED]
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(Print Name of Patient)

Information to be released from:

\_\_\_\_\_  
Name of Designated Facility or Provider

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone Number

Information to be sent to:

GALLAGHER BASSETT SERVICES, INC.  
ATTN: (assigned claims handler)  
Name of Designated Recipient

10050 Regency Circle, Suite 300  
Address

Omaha, NE 68114  
City, State, Zip Code

402.763.1485  
Phone Number

Information to be released:

- The most recent 2 years of pertinent information (chart notes, labs, X-rays and special tests)
- All medical records
- Specific information (Please specify) [REDACTED]

Purpose for which disclosure is being made: Processing of an insurance claim.  
Date of Loss: [REDACTED]

**Patient Authorization:**

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

**\* EXCLUDE the following information from the records released (please initial):**

<input type="checkbox"/> Drug/Alcohol abuse /treatment & diagnosis	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> HIV/AIDS diagnosis/treatment/testing	<input type="checkbox"/> Mental Illness or psychiatric diagnosis/treatment

**My Rights:**

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: \_\_\_\_\_ DATE:           

**(Patient, Guardian\*, or Authorized Representative\*)**

**[\*Please provide documents to prove authority to sign on behalf of the patient]**

**SHALL BE VALID FOR ONE YEAR FROM THE ABOVE DATE  
PHOTOCOPY VALID AS ORIGINAL**