

Claimant:
Employer:

HIPAA RELEASE

I, _____, intend for any agent named in this release to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d and 45 C.F.R. 160-164.

I authorize the disclosure of any information governed by HIPAA to be provided to the following persons: **NCA COMP.**

This is to certify that I, _____
residing at _____ in the Town, Village, or
City of _____ in the State of _____
do hereby release any and all medical and / or psychiatric records to NCA-Neuman
Claim Administrators, Inc. These records will be used for my Workers' Compensation
claim. I authorize the release of any medical and / or psychiatric records or information
in your possession.

Name

Signature

Date