CITY OF HIALEAH

Authorization for Use or Disclosure of Protected Health Information Release Form

I hereby authorize the use or disclosure of my medical information (also known as protected health information) as described below.

1. I, _____, authorize all persons or entities who provide medical treatment to me to disclose the following medical information in your possession to Sedgwick, its employees, agents, subcontractors and/or authorized representative of the City of Hialeah.
2. Please provide Sedgwick/City of Hialeah with any and all information concerning my physical condition included but not limited to, healthcare history, diagnosis, condition, treatment or evaluation and other medical information so that they may use it or disclose it to evaluate, administer and resolve my claim related to injuries I receive on _____.
3. This authorization shall be in force and effect until my claim related to injuries I received on _____ is resolved, at which time this authorization to use or disclose this protected health information terminates. I understand that I may revoke this authorization by notifying the adjuster from Sedgwick, handling the case and Franklin Duharte, Risk Management Manager and Marieta Sotero, Risk Management Coordinator at 501 Palm Ave. 3RD Floor, Hialeah, Florida 33010, in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by Sedgwick/City of Hialeah or the Releasing Party in reliance on it before I revoke it.
4. As the person signing this Authorization for Release of Protected Health Information, I understand that I am giving permission to Sedgwick/City of Hialeah to obtain and use protected health information. I understand that information used or deloused by the recipients may no longer be protected by federal or state law.
5. A copy of this authorization may be accepted with the same authority as the original.

All statements and information given in this authorization Authorization for Use or Disclosure of Protected Health Information are true and accurate to the best of my knowledge and belief.

_____	_____
Name of Applicant (Printed)	Name of Applicant (Signature)
_____	_____
Date	Social Security Number
City of Hialeah	501 Palm Avenue Hialeah, Florida 33010
Employer Name	Employer Address