[redacted]

Medical Authorization
In Accordance with 45 CFR Section 164.508(c) - HIPPA

Upon presentation of this authorization, or a photostatic copy thereof, you are requested to provide the records outlined below to

[redacted]

Patient Information: Name: _____ Social Security No. _____

Date of Birth: ___/___/_____ Other Health Insurance/Group/Plan No.: _____

Healthcare Provider(s) _____

Dates of Service (Check One and Complete Dates of Service if Required)
[] Please provide a complete copy of my file for all date of service

[] Please provide a complete copy of my file for service from _____through _____

Records to be Released (45 CFR § 164.508(c)(1)(i).

[] All Records	[] History & Physical	[] Consultation Reports
[] Emergency Room Records	[] Operative Report	[] Discharge Summary
[] Lab/Pathology Reports	[] Radiology Reports/Images	[] Other

The purpose of this request is for legal review or personal use (45 CFR § 164.508(c) (1)(iv.)).

[] I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(0)).

[] I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR § 164.508(c)(2)(ii)).

[] I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, non-communicable or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire one (1) year from the date of my signature unless I revoke the authorization prior to that time.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative

[redacted]

AUTHORIZATION TO RELEASE EMPLOYMENT RECORDS

TO:

EMPLOYEE:

DOB:

SSN:

This is your full and sufficient authorization to release all employment records to [redacted] their representatives and/or employees, address [redacted] The records are to include, but are not limited to: employment applications, payroll, W-2 and W-4 forms, records of paid and unpaid time off (including records of vacation, medical leave, sick time and other absence), disciplinary actions, withholdings, garnishments, performance reviews, job descriptions, job schedules, assignments and/or appointment history, report of injuries on the job and all records pertaining to workers' compensation including medical information and government documentation.

This information required is for investigative purposes and may be used in legal proceedings.

I understand that I may revoke this consent in writing at any time, but that such revocation may adversely affect the course of the investigation requiring these records. Upon fulfillment of the above stated purpose, this consent will automatically expire without my express revocation. A PHOTOCOPY OF THIS AUTHORIZATION WILL BE TREATED IN THE SAME MANNER AS AN ORIGINAL.

_____ _____

Date

Signature of Employee

_____

Printed Name of Employee

[redacted]

[redacted]

[redacted]

This is a required Accident Statement Form. In order for your claim to be processed in a timely manner, please complete all questions and diagrams on the form. You must sign the form and enclose a copy of your driver's license or state issued identification. Failure to do so will be considered non-cooperation on your behalf and will delay your claim.

Please be advised that any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. Mailing fraudulent documents is considered a Federal Offense under Title 18, United States Code Section 1341 punishable by fines and imprisonment.

Claim Number # [redacted] Adjuster [redacted]

Section A: Vehicle Information

Year Make	Model	Color	VIN	
License Plate #	License State	Current Mileage	Number of People In Vehicle	
Describe all parts damaged in this accident (attach any appraisals obtained)				
Describe any damage to the vehicle previous to this accident				
Vehicle Drivable (Yes/No)	(If Not Drivable Vehicle Location)	(Phone at Location)	Purchase Date	Amount Paid
Registered Owner	Home Phone	Work Phone	Mobile Phone	
Owner's Address	City	State	Zip	
Vehicle Lienholder (Mark "none" if you have a clear title, send copy of title with form)				Account Number
Lienholder Address	City	State	Zip	
List all prior claims and/or auto accidents to include insurer and date of loss (Mark "none" if applicable)				
Your Insurance Carrier	Policy Start Date	Policy End Date	Policy Number	

Section B: Driver Information

Name of Driver	Age	Relation to Owner		How Long Driving
Home Address	City	State	Zip	
Business Address	City	State	Zip	
Home Phone	Work Phone	Mobile Phone	Email	
Driver's License	Previous Accidents or Convictions			

[redacted]

[redacted] [redacted]

Claim Number # [redacted] Adjuster [redacted]

Section C: Passengers

Number of passengers Number of injured passengers

1	Name	Age	Sex	Relation to Owner	Contact Phone
	Home Address		City	State	Zip
2	Name	Age	Sex	Relation to Owner	Contact Phone
	Home Address		City	State	Zip
3	Name	Age	Sex	Relation to Owner	Contact Phone
	Home Address		City	State	Zip

Passenger Accident Status	A	B	C	D	E	F	G	H	Name of Medical Facility
Driver	-								
Passenger 1									
Passenger 2									
Passenger 3									

A. Seating Position

1. Front Seat – left side (or motorcycle driver)
2. Front seat – middle
3. Front seat – right side
4. Second seat – left side (or motorcycle passenger)
5. Second seat – middle
6. Second seat – right side
7. Third seat – left side (or motorcycle passenger)
8. Third seat – middle
9. Third seat – right side
10. Sleeper section of cab
11. Enclosed passenger area
12. Unenclosed passenger area
13. Training unit
14. Riding on vehicle exterior
15. Other
16. Unknown

B. Safety System

1. None Used
2. Shoulder and lap belt
3. Lap belt only
4. Shoulder belt only
5. Child safety seat
6. Helmet
7. Unknown

C. Air Bag Status

1. Deployed – front
2. Deployed – side
3. Deployed – both
4. Not deployed
5. Not applicable
6. Unknown

D. Air Bag Switch

1. Switch in ON position
2. Switch in OFF position
3. Switch not present
4. Unknown

E. Ejected From Vehicle

5. Not ejected
6. Totally ejected
7. Partially ejected
8. Unknown

F. Trapped

1. Not Trapped
2. Freed by mechanical means
3. Freed by non-mechanical means
4. Unknown

G. Injured

1. Fatal Injury
2. Incapacitating
3. Non-incapacitating
4. No injury
5. Unknown

H. Transported for Medical Care

1. Not transported
2. EMS (emergency service)
3. Police
4. Other
5. Unknown

[redacted]

[redacted]

[redacted]

Claim Number # [redacted] Adjuster [redacted]

Section D: Other Vehicle

Type of vehicle (Motor Vehicle, Train, Pedestrian, Bicyclist, Other) | Number of Passengers

Year | Make | Model | Color | License Plate # | License Plate State

Driver Name | Home Phone | Work Phone | Mobile Phone | Drivers License

Home Address | City | State | Zip

Owner Name | Home Phone | Work Phone | Mobile Phone | Drivers License

Home Address | City | State | Zip

Section E: Witnesses

1

Name | Home Phone | Work Phone | Mobile Phone

Home Address | City | State | Zip

2

Name | Home Phone | Work Phone | Mobile Phone

Home Address | City | State | Zip

3

Name | Home Phone | Work Phone | Mobile Phone

Home Address | City | State | Zip

Section F: Bodily Injury

1

Name | Location (Driver, Passenger, Pedestrian, Other) | Age | Sex | Fatal (Yes/No) | Date of Death

Home Address | City | State | Zip

Describe Injury | Seatbelt (Yes/No)

2

Name | Location (Driver, Passenger, Pedestrian, Other) | Age | Sex | Fatal (Yes/No) | Date of Death

Home Address | City | State | Zip

Describe Injury | Seatbelt (Yes/No)

3

Name | Location (Driver, Passenger, Pedestrian, Other) | Age | Sex | Fatal (Yes/No) | Date of Death

Home Address | City | State | Zip

Describe Injury | Seatbelt (Yes/No)

[redacted]

[redacted]

[redacted]

[redacted]

Claim Number # [redacted] Adjuster [redacted]

Section G: Description of Accident/Loss

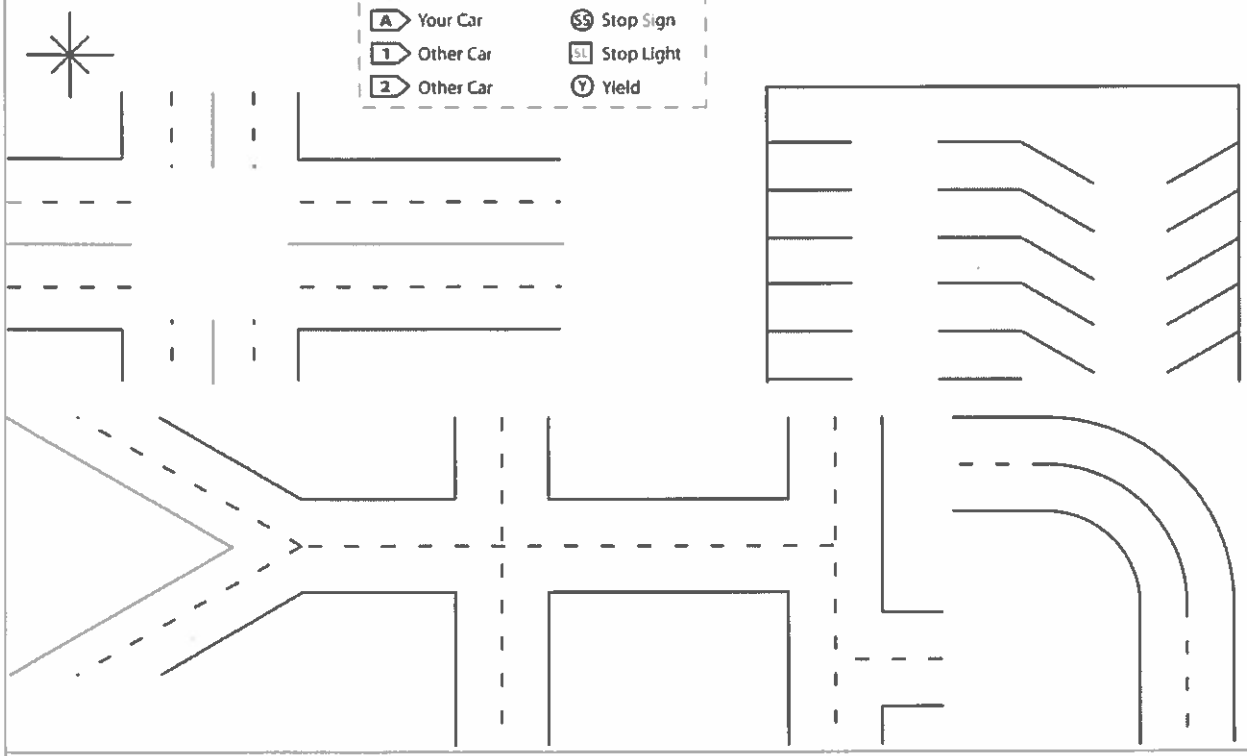
Location of Accident	Date	Accident Report (yes/no)	Police Department	Report #

Weather Conditions

Indicate North

Legend

- A Your Car
- 1 Other Car
- 2 Other Car
- SS Stop Sign
- SL Stop Light
- Y Yield



Illustrate position of the cars at the time of the collision. Show skid marks. Please indicate if any street is more than two lanes or is a one way.

Accident Description

continue description on next page

[redacted]

[redacted]

[redacted]

[redacted]

Claim Number # [redacted]

Adjuster [redacted]

Accident Description *Continued*

Section H: Signature

I understand that in order for my claim to be processed in a timely manner, I am to complete all questions and diagrams on this Accident Statement form. I hereby certify that all information provided by me in this statement is a true, correct, and complete account of all facts of this incident. If I or any person connected to me knowingly present a false or misleading claim for payments of a loss, or knowingly present false or misleading information to an insurance company for the purpose of defrauding or attempt to defraud an insurance company, or provide false information concerning a material fact on an application for insurance, or help any other person commit such acts, I may be guilty of fraud, and may be subject to substantial civil and criminal penalties pursuant to the fullest extent of the laws of the state in which those acts occurred. I understand that mailing fraudulent documents is considered a Federal Offense under Title 18, United States Code Section 1341 punishable by fines and imprisonment.

Print Name

Date

Signature

[redacted]

[redacted]

[redacted]

Department of Resolution

Claims Concerns or Comments

Empower wants to provide the best service possible.

We understand that no one wants to have a claim, and sometimes it's a process you have never gone through before.

If at anytime you have a concern about how your claim is managed or want to make a comment or a complaint you may complete this form and fax it to [redacted] or mail it to:

[redacted]

If you have internet access you can complete this form on line at [redacted]

We'll review your submission and contact you quickly.

Please Complete

Your Name	
Claim Number	
Policy Number	
The Empower Policy Holder	
Your Daytime Phone Number	
Your Evening Phone Number	
Your e-mail	

Please share your comments below:

If you would prefer to leave a voice mail message please call [redacted] and someone from our Department of Resolution will contact you.