



management research services

Name: _____ Maiden name or other: _____
 Address: _____
 Date of Birth: _____ Social Security #: _____

HEREBY REQUEST AND AUTHORIZE: (to be completed by MRS, Inc)

Name: _____
 Address: _____

TO RELEASE THE SPECIFIED INFORMATION FROM MY RECORDS TO:

**MANAGEMENT RESEARCH SERVICES, Inc.,
 P.O. BOX 510304, NEW BERLIN, WI 53151**

For the purpose of:
 LIFE/HEALTH/DI INSURANCE WITH:
 OTHER:

THIS DISCLOSURE INCLUDES THE FOLLOWING INFORMATION:
 All records pertaining to my medical treatment for the period:

I understand that the information to be disclosed may indicate the presence of or include diagnosis, prognosis, and treatment for physical, psychological, psychiatric and emotional illness, treatment of alcohol or drug abuse, communicable or non-communicable venereal disease, Acquired Immune Deficiency Syndrome, HIV testing, Hepatitis A, B, C, and sickle cell anemia.

- | | |
|---|---|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Consultation Report(s) |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Laboratory Report(s) |
| <input type="checkbox"/> Operative Report(s) | <input type="checkbox"/> X-Ray Report(s) |
| <input type="checkbox"/> Pathology Report(s) | <input type="checkbox"/> Doctor/Clinic progress notes |
| <input type="checkbox"/> Other | |

This consent shall remain in effect until:

A photographic or faxed copy of this authorization shall be valid as the original. This consent may be revoked at any time upon written request executed by the undersigned and directed to the releaser, except to the extent that action has been taken in reliance thereon. Patient has a right to inspect and obtain a copy of the record and this authorization. The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the HIPAA rule. Treatment, payment, enrollment, or eligibility of benefits may no be conditioned on obtaining the individuals authorization. Patient has a right to refuse to sign this authorization.

Authorization must be signed by patient or authorized representative of the patient.

Signature:

Date:

Applicant:	_____	_____
Spouse (if applying):	_____	_____
Dependent over 18 (if applying):	_____	_____
Dependent over 18 (if applying):	_____	_____
Witness:	_____	_____