



**PART A TO BE COMPLETED BY PATIENT (MEMBER)**

**AUTHORIZATION FOR RELEASE OF INFORMATION  
GROUP HEALTH BENEFITS**

I AUTHORIZE any physician, medical practitioner, hospital, Veterans Administration Hospital, clinic, other medical or medically related facility, insurance company, consumer reporting agency, employer or group policy holder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to East Bay Drayage Drivers Security Fund (hereinafter called The Fund) or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by The Fund or its authorized claims paying administrator to determine eligibility for benefits or services under a policy. Any information obtained will not be released by The Fund to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., employer, group policyholder, contract holder, or other persons or organizations performing business or legal services in connection with my claim or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of the Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two and one-half years from the date shown.

PATIENT'S SIGNATURE (if other than a minor child)  X _____	MEMBER'S SIGNATURE  X _____	I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICAL OR SUPPLIER FOR SERVICE DESCRIBED BELOW. SIGNED (Member or Authorized Person) X _____
DATE _____		

**PART B ATTENDING PHYSICIAN'S STATEMENT**

1. DIAGNOSIS AND CONCURRENT CONDITIONS (If diagnosis code other than ICD9* used, give name.)				
2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S		EMPLOYMENT?	PREGNANCY?	
EDC _____		No <input type="checkbox"/> Yes <input type="checkbox"/>	No <input type="checkbox"/> Yes <input type="checkbox"/>	
1. DATES OF SERVICES (If previous form submitted to this carrier, you need show only dates since last report.)				
2. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED		3. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION		
4. PATIENT EVER HAD SAME OR SIMILAR CONDITION? (If yes, state when and describe.) No <input type="checkbox"/> Yes <input type="checkbox"/>		5. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? No <input type="checkbox"/> Yes <input type="checkbox"/>		
6. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (unable to work)* SEE NUMBER 12		7. PATIENT WAS PARTIALLY DISABLED*SEE NUMBER 12		
FROM _____ THRU _____		FROM _____ THRU _____		
8. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK*SEE NUMBER 12		9. PATIENT WAS HOUSE CONFINED		
10. HOSPITALIZATION DATES*SEE NUMBER 12		11. DOES PATIENT HAVE OTHER HEALTH COVERAGE? (If yes, identify.) No <input type="checkbox"/> Yes <input type="checkbox"/>		
ADMITTED _____ DISCHARGED _____		FROM _____ THRU _____		
DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE	TELEPHONE
STREET ADDRESS		CITY	STATE	ZIP CODE

\*ICD9—International Classification of Diseases

INDIVIDUAL PRACTITIONERS S.S. NO (Must be furnished under authority of law.) \_\_\_\_\_

ALL OTHERS—EMPLOYER I. D. NO. \_\_\_\_\_

12. \*(MUST HAVE AN ESTIMATED RETURN TO WORK DATE OR CLAIM WILL BE DENIED).

**FORMS OR NOTES SIGNED BY A DOCTOR OF CHIRIOPRACTIC (DC) ARE NOT VALID.**