FARMERS®

National Document Center
P.O. Box 268994
Oklahoma City, OK 73126-8994
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Fax: (877) 217-1389

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby request and authorize the disclosure of protected health information about me as described below:

The name or other specific identification of the person(s) or class of persons, authorized to disclose the information: Medical Providers.

The name or other specific identification of the person(s) or class of persons authorized to receive the information: Farmers Insurance Exchange

Specific description of the information to be disclosed: ______________________

I understand that the information disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

I understand that I may revoke this authorization by notifying the medical provider in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions they took before they received my revocation.

I understand this authorization will expire on (check and complete one):
☐ ______, 20 ____ , OR

☐ On the happening of the following event that relates to me or the purpose of the use or disclosure:

____

This form MUST be fully completed before signing.

______________________________ ______________________
Signature of Patient or Patient's Representative Date

____
Printed Name of Patient

______________________________ ______________________
Printed Name of Patient's Representative (If applicable) Relationship to Patient (If applicable)

(A copy of this signed form will be provided to the patient)

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For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Our insured:______________________
Date of loss:______________________
Claim Unit Number:________________
Injured Party:_____________________
Injured Party DOB:_________________

** PLEASE MAKE SURE TO RETURN BOTH PAGES TO YOUR CLAIMS REPRESENTATIVE ONCE YOU HAVE SIGNED THE FORM. THANK YOU. *