AUTHORIZATION TO RELEASE AND OBTAIN INFORMATION
(Return ALL Pages to TRISTAR)
Tel: (844) 702-2352 Fax: (562) 495-6687
Email: ICSFax@tristargroup.net

TRISTAR

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Any insurance company or claims administrator.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit program or an annuity program.
- Any educational, vocational or rehabilitational organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency (for example, State of California, Employment Development Department (EDD), Social Security Administration, Public Retirement System, Railroad Retirement Board, etc.)

TO GIVE THIS INFORMATION:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
- Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
- Any communicable disease or disorder.
- Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes include: notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the content of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.
- Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.
and:
- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, vocational related information, or eligibility for other benefits (*for example, Social Security Administration, Public Retirement System, EDD, Railroad Retirement Board, claims status, benefit amounts and effective dates, etc.).*

TO TRISTAR, Workers' Compensation Insurer, Long Term Disability Insurer, My Employer and their subsidiaries or representatives.
- I understand that TRISTAR will use the information to determine my eligibility or entitlement for benefits.
- I understand and that this authorization shall remain valid for 12 months from the date of signature.   I understand that I have the right to refuse to sign and to revoke this authorization at any time by sending a written statement to TRISTAR except to the extent it has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair the ability to evaluate or process my claim and may be a basis for denying my claim for benefits.
- I understand that in the course of conducting its business, TRISTAR may disclose to other parties information it has about me. They may release this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for them in connection with my claim.
- I understand that the information disclosed to TRISTAR pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. **(Disability coverage is not subject to the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) and therefore the release of information to TRISTAR is not protected under the Act.)**

I acknowledge that I have read the authorization. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

_____   _____
Name *(please print)*   Social Security Number

_____   _____
Signature of Claimant/Guardian/Representative   Date