Reset

macropro

Workers' Compensation Request

P.O. Box 90459
Long Beach, CA 90809-0459

(800) 696-2511
FAX (888) 696-2270

Order Online at www.macropro.com

CLIENT & BILLING INFORMATION

Order Date: _____ Required Date: _____

Regular ☐ Rush ☐ Super Rush ☐ **($50 Extra per Location)**

Attorney's Name: _____

Firm Name: _____

Address: _____

_____

Phone: ( ) _____ Fax: ( ) _____

File #: _____ Contact Person: _____

Email Address: _____

Ordered By: Attorney ☐ Carrier ☐

Send Invoice To: Attorney ☐ Carrier ☐

Carrier Name: _____

Adjustor Name: _____

Address: _____

_____

Phone: ( ) _____ Fax: ( ) _____

Claim File #: _____ Date of Loss: _____

Email Address: _____

SUBPOENA INFORMATION

Case Caption: _____

vs. _____

WCAB Case Number: _____

☐ **SUBPOENA:** ☐ Records Only ☐ Trial or ☐ Deposition - Appear Only

☐ Trial ☐ Deposition Appear with Records Hostile Witness? Y/N _____

☐ **AUTHORIZATION** Expiration Date _____

Applicant Attorney/Pro-Per: _____

Address: _____

_____

Appearance Address: _____

_____

Judge: _____ Date: _____ Time: _____

COPY RECORDS PERTAINING TO:

Name: _____

AKA: _____

Date of Birth: _____

Social Security Number: _____

SEND COPIES TO:

Carrier:	_____ Paper	_____ CD	_____ Download
Defense Attorney:	_____ Paper	_____ CD	_____ Download
Applicant Attorney:	_____ Paper	_____ CD	_____ Download
☐ Other	_____ Paper	_____ CD	_____ Download

Other Address: _____

_____

SERVE/COPY RECORDS AT:

	Record Codes/ Limit Dates	Medical Summary?
1. Location: _____ Phone Number: ( ) _____	Codes: _____	Yes ☐
Address: _____	Limit Dates: _____	
2. Location: _____ Phone Number: ( ) _____	Codes: _____	Yes ☐
Address: _____	Limit Dates: _____	
3. Location: _____ Phone Number: ( ) _____	Codes: _____	Yes ☐
Address: _____	Limit Dates: _____	

☐ Additional Locations Attached

Special Instructions: _____

RECORD CODES

SEND MORE: Forms ☐ Envelopes ☐

MEDICAL RECORDS

M - Medical Records
B - Medical Billing
R - Film Reports
P - Psychiatric Records
S - Sign-in Sheets

FILMS

X - X-rays
Q - MRI's
Z - CT Scans

EMPLOYMENT

E - Employment Records
Y - Payroll Records

OTHER

A - Academic Records
I - Insurance Records
T - Court File
W - WCAB File
D - EDEX Report
O - Other _____

macro-pro

HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECORDS

1.) I hereby authorize: _____
Name of Facility with Records/Disclosing Party

2.) To disclose to: _____
Name of Requesting Party (Requester): Insurance Carrier/Third Party Administrator/Self-Insured Employer/Attorney Firm

and/or their attorneys, through **Macro-Pro their agent**, to review, inspect, and/or photocopy **any and all of the following from any and all dates** which are in your possession or control:

_____ _____/_____/_____
Name of Patient (List Other Names Used) **Date of Birth**

- **Medical records**, to include but not limited to: Medical files, reports, charts, graphs, notes, tests, x-rays, MRI's, billings and laboratory reports.
- **Employment and/or Union records** to include but not limited to: Personnel file, medical and insurance, pension benefit records and wage records.
- **EDD Disability and Unemployment Records**
- **Police, Prison or Probation Records**
- **Scholastic Records**
- **Insurance and Claim Records**

SENSITIVE INFORMATION: By initialing below, I hereby authorize the release of information concerning:

____ **Psychiatric and Mental Health Information**
Initial

____ **HIV and/or AIDS Information**
Initial

____ **Alcohol and/or Drug Information**
Initial

____ **Genetic Records**
Initial

____ **Sexually Transmitted Disease Information**
Initial

Date Range of Records to be Released ____/____/_____ to _____

The health information authorized on this form will be used for the following purposes only**:**
Discovery for a Liability or Workers' Compensation claim.

DURATION: This authorization shall become effective immediately and shall remain in effect until_____or for ONE full year from date of signature.

REVOCATION: This authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt but will not be effective to the extent that the requester or others have acted in reliance upon this authorization. **Written revocation is to be sent to those parties listed on line 1.) and line 2.) above.**

PROHIBITION OF USAGE, TRANSFER OR REDISCLOSURE OF INFORMATION: Except as required by state or federal laws, use of information released for other than the stated purpose or redisclosure or transfer of this information to any person or entity not named herein is prohibited. An additional written authorization must be obtained for any proposed new use of the information or its redisclosure or transfer of such information. Authorized information may be subject to redisclosure by the recipient and no longer protected by the privacy regulations.

I understand that I have the right to receive a copy of this authorization.
A copy of this authorization shall be considered as valid as the original.

_____ _____ _____
Signature **Print Name** **Date**

_____
If Signed by Other than Patient, Indicate Relationship

MEDICAL HISTORY

Employee	Employer
Address	Date of Injury
City, State Zip code	Daytime Telephone Number

Please list below all hospitals and doctors including medical doctors (MD), chiropractors (DC), osteopaths (DO), physical therapists, psychologists, psychiatrists, or any other medical care provider you have seen in the last 10 (ten) years.

Name Address and Phone #'s of Providers	Treatment Date(s)	Type of Treatment