Key Risk
a Berkley Company

Authorization

The undersigned has filed a claim for workers compensation benefits (hereafter referred to as the "Claim"). The amount and type of information sought pursuant to this authorization will depend upon the nature of the Claim, but will be used solely to facilitate determination regarding validity of the Claim and the payment of benefits or the administration of the insurance program under which the Claim has been made. Authorizing the disclosure of information is voluntary, and acceptance of the Claim will not be conditioned upon signing this authorization. This authorization is subject to revocation at any time, except to the extent that any party has already acted in reliance upon it. Any revocation must be submitted in writing to Key Risk, P. O. Box 49129, Greensboro, NC 27419.

The undersigned authorizes the release of information and communication between his or her health care provider(s) (including, without limitation, medical laboratories, pharmacies, pharmacy benefit managers, and medical suppliers) and representatives of Key Risk Management Services/Berkley Insurance Company ("Key Risk").

This release of information applies to all applicable medical records, medical information, bodily fluid and tissue samples, and benefit payment information with respect to any illness, injury, medical history, consultation, prescription, treatment, or benefit, and copies of all applicable records thereof, which may be appropriate or necessary throughout the course of this Claim. This authorization shall specifically include, but shall not be limited to, medical records, medical information and benefit payment information pertaining to or relating to the treatment of Acquired Immune Deficiency Syndrome, HIV, mental illness, and drug or alcohol related problems.

The undersigned also authorized the Social Security Administration and the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors, to release to Key Risk information concerning his or her workers compensation injury, entitlement dates and benefit amounts.

The undersigned further authorizes Key Risk to release any such information to its reinsurers, attorneys, second injury fund consultants, or to medical laboratories, medical peer review panels, CMS, state insurance or fraud agencies, managed care vendors, industry anti-fraud or law enforcement organizations, research and statistical reporting organizations, or the undersigned's employer and its excess insurer, to the extent that Key Risk considers doing so to be reasonably appropriate or necessary for the purposes of its administration of the Claim or the insurance program under which the Claim has been made.

Information disclosed to Key Risk is from records whose confidentiality is protected by various state or federal laws. Any further disclosure of this information may no longer be subject to certain protections provided under federal privacy regulations. Unless revoked earlier by the undersigned, in writing, this authorization shall be valid for three years after Key Risk has closed the Claim. A copy of this authorization is to be considered as valid as the original.

Employee Signature _____ **Date** _____

Employee Name _____ **Employer** _____
(Please Print) **(Please Print)**

Claim Number _____ **Date of Birth** _____