MEDICAL AUTHORIZATION AND CONSENT TO RELEASE INFORMATION

TO ANY HOSPITAL OR DOCTOR CONCERNED:

The undersigned person hereby consents to and by this authorization or any photocopy thereof, hereby authorizes the release to my employer or any agent or designee of my employer and my employer's insurance carrier and/or third party administrator, of any and all medical reports, histories, findings, prognosis, bills, information and other documents relating to any medical treatment, hospitalization, prescription drugs or other medical services or supplies, including psychiatric treatment or treatment for alcoholism or drug abuse of such patient.

The undersigned understands that my employer and its agents, designees and insurance carrier/third-party administrator, may from time to time, find it necessary to obtain information verbally from my treating health care providers and such contact is hereby authorized.

The undersigned person(s) understands and hereby acknowledges that the information above or certain portions thereof may be protected from disclosure without this signed authorization of federal and state privacy and confidentiality laws. A photocopy of this authorization will serve as an original.

Name: ____

Claim#: ____

SSN#: ____

Date of Birth: ____

____
Patient – Please print name

____
Patient – Signature

____
Date

Return this form to:
Ariel Third Party Administrators, Inc.
P.O. Box 212159
Columbia, S.C. 29221
Claims: (855)222-6369 or (803)365-0050 Fax: (803)365-0098