

P.O. Box 90459

P - Psychiatric Records

S - Sign-in Sheets

Long Beach, CA 90809-0459

Workers' Compensation Request

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CLIENT & BILLING INFORMATION Carrier Required Date: _____ Ordered By: Attorney Order Date: __ Regular Rush (\$25 Extra per Location) Send Invoice To: Attorney Carrier Carrier Name: _ Attorney's Name: ___ Adjustor Name: _____ Firm Name: _ Address: Address: __) _____ Fax: ()_____ Fax: (Phone: (Date of Loss: Claim File #: _____ Contact Person: _____ Email Address: Email Address: SUBPOENA INFORMATION Applicant Attorney/Pro-Per: Case Caption: ___ VS. _ Address: WCAB Case Number: ___ Email Address: □ SUBPOENA: □ Records Only □ Trial or □ Deposition - Appear Only Appearance Address: ☐ Trial ☐ Deposition Appear with Records Hostile Witness? Y/N ___ Judge: Date: ☐ AUTHORIZATION Expiration Date ___ **COPY RECORDS PERTAINING TO:** SEND COPIES TO: Paper CD Download Name: ___ Defense Attorney: Paper ____ CD ____ Download __ Paper ____ CD __ Applicant Attorney: Download AKA: __ Paper ____ CD ____ Download Date of Birth: ___ ☐ Other Social Security Number: ____ Other Address: ____ SERVE/COPY RECORDS AT: Record Codes/ Order Limit Dates Medical Synopsis? Medical Synopsis? 1. Location: Phone Number: (Codes: Injury-Focused? Limit Dates:____ Condensed? Address: ___ Medical Synopsis? Codes:___ 2. Location: ___ Phone Number: (Injury-Focused? Condensed? Limit Dates: Address: ___ Medical Synopsis? Phone Number: (Codes:_ 3. Location: ___ Injury-Focused? Limit Dates:___ Condensed? Address: _ ☐ Additional Locations Attached Special Instructions: ___ **RECORD CODES** SEND MORE: Forms □ Envelopes □ MEDICAL RECORDS **FILMS OTHER** M - Medical Records D - Digital Imaging (X-Rays, CTScans, MRIs) A - Academic Records I - Insurance Records B - Medical Billing T - Court File W - WCAB File H - Ambulance Records R - Film Reports **EMPLOYMENT**

E - Employment Records Y - Payroll Records

O - Other___



HIPAA-COMPLIANT AUTHORIZATION FOR THE RELEASE OF RECORDS

1.) I hereby authorize:				
,	Name of Facility with Records/Disclosing P	arty		
2.) To disclose to:				
and/or their attorneys,	Requesting Party (Requester): Insurance Country through Macro-Pro their ageing from any and all dates where the control of the country is the control of the country in the country in the country is the country in the country in the country in the country is the country in the	ent , to review, ins	pect, and/or p	hotocopy any
			_//	
Name of Patient (List Other	Names Used)	Dat	e of Birth	Last 4 of SSN
 tests, x-rays, M Employment a insurance, pens EDD Disability 	Is, to include but not limited to RI's, billings and laboratory re nd/or Union records to inclusion benefit records and wage and Unemployment Record or Probation Records	ports. de but not limited records. • \$ Is	to: Personnel Scholastic Re	file, medical and cords d Claim Records
concerning:	ATION: By initialing below, I h	·		
Psychiatric and Initial	Mental Health Information		or AIDS Info	rmation
Alaahal and/an	Drug Information	Initial Genetic	Records	
Initial		Initial		
Sexually Transr	mitted Disease Information			
	ls to be Released//	to		
The health information	authorized on this form will b	e used for the fol		
	orization shall become effecti or for ONE full year from date	•	nd shall remai	n in effect
between now and the effective upon receipt reliance upon this auth 1.) and line 2.) above PROHIBITION OF US required by state or federedisclosure or transfer additional written authorized.	tuthorization is subject to writt disclosure of information by the but will not be effective to the norization. Written revocation. AGE, TRANSFER OR REDISTRAL laws, use of information release of this information to any person ization must be obtained for any of such information. Authorized	ne disclosing party extent that the re n is to be sent to SCLOSURE OF I ased for other than or entity not name proposed new use	y. My written requester or other those parties NFORMATION the stated purpod herein is proher of the informate	evocation will be ers have acted in s listed on line L: Except as lose or libited. An line or its
	protected by the privacy regulation distinction of the privacy regulation of the protection of the privacy regulation	ons. Treatment, pa	yment, enrollme	ent or eligibility for
I unders	tand that I have the right to this authorization shall be o			
Signature	Prir	t Name		Date
If Signed by Other than Pati	ent, Indicate Relationship			



MEDICAL HISTORY			
Employee	Employer		
Address	Date of Injury ———————————————————————————————————		
City, State Zip code			
Please list below all hospitals and doctors in osteopaths (DO), physical therapists, psychoprovider you have seen in the last 10 (ten) y	ologists, psychiatrists, or		
Name Address and Phone #'s of Providers	Treatment Date(s)	Type of Treatment	