clarklovehutson
A Professional Limited Liability Company

3M Company ("3M") Combat Arms™ Earplugs Claim

Required Medical Authorization Forms

This file contains the required Medical Authorization Forms necessary for us to order your medical records, which are critical for us to prove your case.

Please follow the following instruction carefully. We need you to completely ***fill out ONLY the highlighted section*** of the forms, sign where indicated, but ***DO NOT DATE*** them. Please return them to our office using one of the following methods:

1. Mail the completed authorizations to our office;

   Clark, Love & Hutson
   Attn: 3M Department
   440 Louisiana St, Suite 1600
   Houston, TX 77002

2. Scan & Email the completed authorizations to our office at **3Mearplugs@triallawfirm.com**; or

3. Fax a legible copy of the authorizations to 713-759-1217.

If you have any question, please do not hesitate to contact us at **1-888-278-4500** or by email at **3Mearplugs@triallawfirm.com**.

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Previous edition unusable
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REQUEST PERTAINING TO MILITARY RECORDS

Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/military-service-records/
To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS *(Furnish as much information as possible.)*

1. NAME USED DURING SERVICE (last, first, full middle)	2. SOCIAL SECURITY #	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT *(For an effective records search, it is important that ALL service be shown below.)*

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE	–			☐	☐	
b. RESERVE	–			☐	☐	
c. STATE NATIONAL GUARD	–			☐	☐	

6. IS THIS PERSON DECEASED? ☐ NO ☐ YES - ***MUST*** *provide Date of Death if veteran is deceased:* _____

7. DID THIS PERSON RETIRE FROM MILITARY SERVICE? ☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☐ **DD Form 214 or equivalent.** Year(s) in which form(s) issued to veteran: _____

This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next-of-kin, or other persons or organizations, if authorized in Section III, below. **An UNDELETED DD214 is ordinarily required to determine eligibility for benefits**. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost.
An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: ☐ I want a **DELETED** copy.

☐ **Medical Records** Includes Service Treatment Records, Health (outpatient) and Dental Records. ***IF HOSPITALIZED (inpatient)*** *the FACILITY NAME and DATE (month and year) for EACH admission* ***MUST*** *be provided:* _____

☐ **Other** (Specify): _____

2. PURPOSE: (Providing information about the purpose of the request is **strictly voluntary;** however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

☐ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☐ Other (explain)

Explain here: _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER NAME: _____

2. ☐ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section I, above.

☐ I am the DECEASED VETERAN'S NEXT-OF-KIN ***(MUST submit Proof of Death.*** *See item 2a on instruction sheet.)*

\- _____
(Relationship to deceased veteran)

☐ I am the VETERAN'S LEGAL GUARDIAN ***(MUST submit copy of Court Appointment)*** or AUTHORIZED REPRESENTATIVE ***(MUST submit copy of Authorization Letter or Power of Attorney)***

☐ OTHER _____
(Specify type of Other)

3. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

Clark, Love & Hutson G.P.
Name

440 Louisiana Street Suite 1600
Street Apt.

Houston TX 77002
City State Zip Code

* This form is available at ***http://www.archives.gov/veterans/military-service-records/standard-form-180.html*** on the National Archives and Records Administration (NARA) web site. *

4. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct and that I authorize the release of the requested information. *(See items 2a or 3a on accompanying instruction sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request if for archival records.)*

Signature Required - Do not print **Date**

Daytime phone Fax Number

Email address

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)* ☐ OUTPATIENT ☐ INPATIENT ☐ BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☐ OTHER *(Specify)*
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION ☐ DATE *(YYYYMMDD)* ☐ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR s164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE: ☐ AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

Reset

MEDICAL AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION

The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure is:

PATIENT INFORMATION		
First Name:	Middle Initial:	Last Name:
Alias/Maiden Name(s):		Home Phone:
Home Address:		
Date of Birth:	Social Security Number:	

FACILITY INFORMATION	
Name: PLEASE LEAVE THIS SECTION BLANK	
Date Begin: DO NOT DATE	Date End: DO NOT DATE

Information to be disclosed:

☐ Operative Report	☐ Intraoperative Nurse Notes	☐ Most Recent History & Physical
☐ Itemized Billing Statement	☐ Doctor's Notes	☐ Pharmacy Records
☐ Complete Chart	☐ Test Results	☐ Insurance Records

Other: _____

I authorize the above-named individual or organization to disclose the above-named patient's health information, as described below, for the purpose of: "at the request of the individual" to the following recipients or any of their representatives:
Clark, Love & **Hutson, GP** | 440 Louisiana, Suite 1600, Houston, Texas 77002 | Telephone: 713-757-1400 | Facsimile: 713-759-1217

This authorization shall also serve to permit a representative of **Clark, Love** & **Hutson, GP** to conduct a personal review of all medical information that you may have pertaining to the patient named above and to orally discuss this information with you.

I understand that the information in the patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse.

This authorization shall remain in full force and effect until it expires three years from the date set forth below. **PHOTOCOPIES OF THIS RELEASE ARE VALID.**

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing by sending or presenting my written revocation to the Privacy Contact of the health care provider named above. I understand that the revocation of this authorization will not apply to the extent that the health care provider has taken action in reliance thereon; or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that you may transmit my protected health information electronically in the course of my representation.

I understand that authorizing the disclosure of this health care information is voluntary. I can refuse to sign this authorization. I understand that my refusal to sign this authorization does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits or enrollment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of the patient's health information by the recipient, resulting in the health information no longer being protected by federal or state confidentiality rules.

DO NOT DATE

Signature: _____ Date: _____
(Patient and/or Legal Representative)