

**Authorization to Release Medical Records** This authorization contains the **core elements** outlined in the Health Insurance Portability Accountability Act (HIPAA). A property/casualty insurer is submitting this authorization.

Patient's Name: ROBERT PLOCK

Social Security Number: \*\*\*-\*\*-\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Loss: \_\_\_\_\_

1. I authorize the use or disclosure of the above named individual's health information as described below for the purpose of handling their underinsured motorist claim.
2. The following individuals or organization are authorized to make the disclosure: all persons with knowledge of my medical history
3. The following persons or class of persons may receive disclosure or protected health information about the above named person: Allstate Insurance Company.
4. The type of information to be disclosed includes: Allstate Insurance Company may request information related to my injury on January 25, 2013, including information related to diagnoses, treatment records, bills and assessments of my current and expected physical condition. Additionally, Allstate Insurance Company may request my medical history as it relates to this injury. This information may include but is not limited to historical medical records, past physical condition, diagnoses, and treatment records and bills. Allstate Insurance Company may either review or photocopy this information.
5. \_\_\_\_\_ By **initialing** this area, I understand that the information in my health records may include information indicating the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS) or Human Immune Deficiency Virus (HIV). It may also include information about behavioral and/or mental health services and/or treatment for alcohol and/or drug abuse.
6. Unless otherwise revoked, this authorization will expire on the following date, event or condition: until my claim with Allstate Insurance Company is legally concluded.
7. I also understand that I can revoke this authorization at any time by notifying company in writing. I understand that the revocation will not apply to information that has been released in response to this authorization.
8. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

I understand that THIS IS NOT A RELEASE OF MY CLAIM. I understand that the evaluation of my claim is based on the information available to Allstate Insurance Company. I understand that signing this form does not mean I have settled my claim.

#### CONDITION OF TREATMENT

The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

**Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**

#### Use of Information

Allstate Insurance Company and its representatives will use this information to verify and evaluate my claim in order to determine an appropriate resolution. In some instances, Allstate Insurance Company may also furnish the information to professional organizations whose purpose is to detect and deter insurance fraud. We may furnish it to other insurance companies to whom a claim has or may be submitted. We may disclose copies of the bills and or medical records to third parties as needed to seek reimbursement or repayment of benefits paid under the policy.

A photocopy of this authorization is as valid as the original.

\_\_\_\_\_  
Signature of patient or authorized Legal Guardian, Health Care Agent, or other authorized Personal Representative

\_\_\_\_\_  
Date:

\_\_\_\_\_  
If signed by a Legal Representative, relationship to patient

Claim Number: 0291823375 JPF

Insured: ROBERT PLOCK

0291823375 JPF

3001020130705TR001018046002005028016



## MEDICAL PROVIDER/EMPLOYER INFORMATION

To assist us in processing your claim, please complete this form and return it to Allstate Insurance Company with the medical and/or wage authorization. We will need to request copies of your medical records and itemized bills in order to properly evaluate your injury claim. Providing the proper names and addresses of all providers who have treated as a result of this claim will help in expediting the handling of the claim. If more space is needed than the form allows please continue on the backside. If you need to add any medical providers in the future, please contact your claim representative. **Please return promptly.**

Claim: 0291823375

Insured: ROBERT PLOCK

Claimant:

Date of Loss: January 25, 2013

Our Fax Number: 866-440-5952

*(REMAINDER OF FORM IS FILLED OUT BY RECIPIENT)*

### Providers:

Hospital or Emergency Care Center: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone #: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

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Treating Physician (or Primary Care Physician): \_\_\_\_\_

Name of Clinic Practicing at: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone #: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

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Other Treating Provider: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone #: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

0291823375 JPF

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## Employers

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

\_\_\_\_\_

Employer's phone number: \_\_\_\_\_

Occupation and Duties: \_\_\_\_\_

\_\_\_\_\_

Supervisor or contact person: \_\_\_\_\_

Pay Rate: \_\_\_\_\_ Hourly/Salary \_\_\_\_\_

If hourly, please specify the number of hours worked per week: \_\_\_\_\_

Do you normally work overtime or have a shift differential? Yes No

If yes, please explain: \_\_\_\_\_

How much time did you lose from work? \_\_\_\_\_

Please specify dates missed: \_\_\_\_\_

Which medical provider was involved in your medical leave from work? \_\_\_\_\_

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Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

\_\_\_\_\_

Employer's phone number: \_\_\_\_\_

Occupation and Duties: \_\_\_\_\_

\_\_\_\_\_

Supervisor or contact person: \_\_\_\_\_

Pay Rate: \_\_\_\_\_ Hourly/Salary \_\_\_\_\_

If hourly, please specify the number of hours worked per week: \_\_\_\_\_

Do you normally work overtime or have a shift differential? Yes No

If yes, please explain: \_\_\_\_\_

How much time did you lose from work? \_\_\_\_\_

Please specify dates missed: \_\_\_\_\_

Which medical provider was involved in your medical leave from work? \_\_\_\_\_

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**Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**





ALLSTATE GROUP-CLAIMS

Dallas MCO

8675 Freeport Pkwy, E2

Irving TX 750632576

UNITED STATES

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ALLSTATE GROUP-CLAIMS

Dallas MCO

8675 Freeport Pkwy, E2

Irving TX 750632576

UNITED STATES

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The office identified above provides claims handling services for the Allstate Group of Insurance Companies, including the underwriting company referenced on the documents accompanying this insert.





**Allstate**  
You're in good hands.

Dallas MCO  
8675 FREEPORT PKWY, E2  
IRVING TX 75063



ROBERT PLOCK  
6827 LATTA PKWY  
DALLAS TX 752276043

August 08, 2013

INSURED: ROBERT PLOCK  
DATE OF LOSS: January 25, 2013  
CLAIM NUMBER: 0291823375 JPF

PHONE NUMBER: 800-767-7619  
FAX NUMBER: 866-440-5952  
OFFICE HOURS:

Re: Please Contact Us About Your Claim

Dear ROBERT PLOCK,

I'm writing to let you know that I have been unable to reach you by phone to discuss the claim listed above. Before I can review this claim I need to discuss it with you, so please call me as soon as possible at the number listed above.

I am in the office from 8 am to 4:30 pm Monday through Friday.

If I am not available when you call, please leave a message with a telephone number where I can reach you. I will get back to you as soon as I can. If you have already spoken to the Allstate Insurance Company claim representative after the above date, please disregard this letter.

Sincerely,

**POWNIE FIERRO**

POWNIE FIERRO  
800-767-7619 Ext. 8716505  
Allstate Insurance Company





**Allstate**  
You're in good hands.

Dallas MCO  
8675 FREEPORT PKWY, E2  
IRVING TX 750632576



ROBERT PLOCK  
6827 LATTA PKWY  
DALLAS TX 752276043

July 05, 2013

INSURED: ROBERT PLOCK  
DATE OF LOSS: January 25, 2013  
CLAIM NUMBER: 0291823375 JPF

PHONE NUMBER: 800-767-7619  
FAX NUMBER: 866-440-5952  
OFFICE HOURS:

## Re: Important Information Regarding Your [Uninsured/Underinsured] Motorist Bodily Injury Claim

Dear ROBERT PLOCK,

This letter acknowledges your notice of intent to submit an Uninsured or Underinsured Motorist claim.

This claim is acknowledged subject to confirmation of coverage and compliance with all of the terms and conditions of the policy and the underlying statute. Please take the following steps to help comply with the terms and conditions of the policy and to assist us in processing your claim:

- 1 Protect the Company's right of subrogation and do not settle with an adverse party without reasonable notice to the Company so we can determine a proper course of action.
- 2 Assist us in proving the adverse party has no insurance, or, in the case of an underinsured motorist, assist us in proving the extent of the underlying liability coverage, including any applicable liability coverage available to the adverse party by virtue of status as a resident relative, employee, or umbrella policyholder, etc.
- 3 Sign and return the enclosed medical and wage authorizations. These will allow me to obtain relevant information, such as office notes and medical reports pertaining to the diagnosis and treatment of your injury. I also will be able to verify your income loss with your employer.
- 4 Send a list of medical providers you have seen or plan to see.
- 5 Promptly send me your medical bills for treatment related to injuries sustained in this accident.
- 6 Please let me know the name and address of your employer if you are losing time from work. Please advise me if you are self-employed. We may require additional information.
- 7 Communicate with us in writing before taking any action that could effect the claim.

If the claim is payable, and we can agree upon a value, Allstate Insurance Company would like to settle the matter without delay. If we cannot agree upon liability or damages, please bear in mind that the policy terms and conditions are conditions precedent to any hearing, and we are not unreasonably delaying the matter when we insist upon compliance before any hearing.

0291823375 JPF

