UNION PACIFIC RAILROAD COMPANY
AUTHORIZATION TO USE OR DISCLOSE
HEALTH INFORMATION
(HIPAA COMPLIANT)

I HEREBY AUTHORIZE any doctor, hospital, rehabilitation counselor, or any other provider of medical or rehabilitation services to me, to release the information specified below to **UNION PACIFIC RAILROAD COMPANY ("Union Pacific").**

CLAIMANT NAME	
SOCIAL SECURITY NO.	
DATE OF INJURY	

I UNDERSTAND that the information authorized includes matters with respect to loss or injuries sustained on the date shown above.

I AUTHORIZE the release of my medical records, including any information available as to my diagnosis, treatment prognosis with respect to any physical or mental condition and/or the treatment thereof; as well as my medical history, or non-medical information to Union Pacific or to its representatives.

I UNDERSTAND that the information furnished will be used to evaluate and verify my claim for personal injuries. The information obtained will not be released to anyone by Union Pacific, except to persons or organizations performing a service related to the above claim. Any information released by Union Pacific may no longer be subject the federal privacy protections and is subject to redisclosure by the recipient.

I UNDERSTAND that I may revoke this authorization by notifying the Union Pacific Claims Representative in writing.

I AGREE that a photocopy of this Authorization shall be as valid as the original. This Authorization shall expire 90 days following settlement, if any, of my above noted personal injury claim.

SIGNED AT _____ (City, State), this _____ (date) day of _____ (month), 200___ (year).

_____
(Claimant Signature)

WITNESSES:

_____

_____

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