

**D.W. Hannah**

---

**From:** D.W. Hannah [dwh@bleupwl.org]

**Sent:** Sunday, May 18, 2003 12:46 PM

**To:** 'Tony Ortiz'; 'Benny Loudermilk'; Brent Johnson; 'Dennis Reeves'; 'Ken Sorensen'; 'Patty Doolette'; 'Rod McClure'; 'T.J. Gowan'; 'Art Ray'; 'Bill Hill'; 'C.H. Fleming'; 'Craig Carstenson'; 'Dave Bednarczyk'; 'Don Carroll'; 'Jim Booth'; 'Jim Fender'; 'Larry Law'; 'Lindy Klock'; 'Randy Saunders'

**Subject:** Union Pacific Authorization to Use or Disclose Health Information Forms

Brothers and Sister Patty:

Attached is a fax copy of UP Authorization to use or Disclose Health Information Form. The first copy is a "clean" copy and the second copy is one that has several lines drawn through the information BEFORE IT IS SIGNED.

You should instruct every member BEFORE signing this form they should cross out the words as so indicated on the second copy.

This information was received from designated legal council and is extremely important.

Fraternally,

Bill

5/18/2003



**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").

<b>CLAIMANT NAME</b>	
<b>SOCIAL SECURITY NO.</b>	
<b>DATE OF INJURY</b>	

**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 \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_.

(City, State) (date) (month) (year)

**WITNESSES:**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Claimant Signature)



**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").

<b>CLAIMANT NAME</b>	
<b>SOCIAL SECURITY NO.</b>	
<b>DATE OF INJURY</b>	

**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 [redacted] condition and/or the treatment thereof; as well as my medical history, [redacted] 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, [redacted]

**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 \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_.

(City, State) (date) (month) (year)

**WITNESSES:**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Claimant Signature)