HIPAA AUTHORIZATION

I authorize GulfWestern Corporation, or its agent, subsidiary or affiliate to obtain any medical records (excluding psychotherapy notes) from any physicians, hospitals and/or other health care providers concerning my care. I also authorize any physicians, hospitals, and/or other health care providers to furnish any medical records (excluding psychotherapy notes) concerning my care to GulfWestern Corporation, or its agent, subsidiary or affiliate. This information is needed to evaluate my health condition and continued eligibility for employment and insurance coverage. I understand that the entities indicated above can request medical records for up to the past 10 years. I further authorize GulfWestern, or its agent, subsidiary or affiliate to require me to submit to an alcohol or drug test following any on the job injury for which I seek medical treatment, and to receive the results.

I understand that I may revoke this Authorization at any time by submitting written notice to GulfWestern Corporation.

I understand that the information disclosed by this authorization could be re-disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements. GulfWestern, its affiliates, its employees, and officers are not legally responsible or liable for the re-disclosure of the information indicated on this authorization.

_____ _____

Signature of Individual Date

_____

Print Name of Individual