WORKERS' AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR WORKERS' COMPENSATION PURPOSES (HIPAA COMPLIANT)

I, (Print Worker's Name) _____, hereby authorize the health care provider (HCP) the use or disclosure of my health information as described in this authorization.

1. INFORMATION

Date of Birth _____/_____/_____ Date of Injury _____/_____/_____ SSN _____-_____-_____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ - _____ Alternate Phone (_____) _____ - _____

2. RELEASE

I authorize the Health Care Provider (HCP) or any member or employee of its office or association who has examined or treated me, as well as any hospital or treatment facility in which I have been a patient, to disclose and release complete and legible copies of any and all information concerning my physical or psychiatric condition, care and treatment, to my employer, insurance carrier/third party administrator and/or their attorneys, and/or duly authorized representatives of the State Workers' Compensation Administration and its current medical cost containment contractor or their duly authorized agents. Copies of all documentation released pursuant to this authorization shall be sent to the agency requesting the information and to me.

3. I understand the following information will be released pursuant to a work-related/occupational injury or illness/workers' compensation claim: medical reports; clinical notes; nurses' notes; patient's history or injury; subjective and objective complaints; x-rays; test results' interpretation of x-rays or other tests (including a copy of the report); diagnosis and prognosis; hospital bills; bills for services the HCP has rendered; payments received; and any other relevant and material information in the HCP's possession. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. This Authorization also includes, if physical therapy records, and all outpatient records. I understand that I have the right to restrict the information that may be provided by signing this authorization to the extent provided by law.

CONDITIONS

4. I understand the purpose of this request is to determine the proper level of worker's compensation benefits and may include information regarding any of the following; to determine my occupational injury or illness status; to determine my eligibility for workers' compensation benefits; to determine my current and future medical status after occupational injury; to determine my current medical status and/or return-to-work capability.

5. Right to revoke: I understand I have the right to revoke this authorization at any time by notifying my employer, insurance carrier/third party administrator. I understand that the revocation is only effective after it is received and logged by that company and that any use or disclosure made prior to the revocation under this authorization will not be affected by the revocation. I further understand that my revocation of this authorization may affect my ability to receive occupational injury or workers' compensation benefits governed by this revocation.

6. I understand that my personal health information disclosed pursuant to this authorization may be re-disclosed and may no longer by protected by federal privacy laws or regulations. My personal health information may be released to any of the following: the employer, the worker's compensation insurer/third party

administrator, any court on any action or proceeding relating to this matter; experts retained or consulted by and party; and any of their agents, employees, or representatives. I specially authorize and consent to any such disclosure and re-disclosure.

7. I understand that information to be released pursuant to a work-related/occupational injury or illness/workers' compensation claim may also be released to the insurance carrier/third party administrator and its current medical cost containment contractor or their duly authorized agents.

8. A hard or electronic copy of this Release, which contains my signature, shall be considered as effective and valid as the original, and shall be honored by those to whom it is sent or provided for a period of one (1) year.

9. This Release authorizes personal or telephonic conferences or correspondence directly between any healthcare provider and a representative of my employer, its attorney, insurance carrier/third-party administrator to discuss my case and is solely for the release of medical documentation/information as set forth herein.

10. I understand I am entitled to a copy of this authorization and to any records provided hereunder. I am requesting a copy of this authorization (circle) YES NO - If Yes, I have received a copy _____ (initial). I understand this authorization will expire within one (1) year of the date I signed it, unless I revoke it earlier, pursuant to Paragraph 5.

Signature of Employee _____ Date _____