TO CURRENT PROVIDER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS BY A HOSPITAL/PROVIDER FOR THE PURPOSE OF ADJUSTING A WORKERS COMPENSATION CLAIM FOR BENEFITS

Patient Name:
Date of Birth:
Claim Number:
Date of Injury/Illness:

I, the undersigned, authorize:

_____
(HOSPITAL/PROVIDER)

to release my medical records, reports and other protected health information ("PHI") to:

_____
(PERSON OR ENTITY TO WHOM INFORMATION IS TO BE DISCLOSED)

and its attorneys and/or representatives. The PHI to be disclosed is relevant medical records and reports, and prescribed medications, relating to my medical treatment/consultation/examination and/or diagnostic procedures performed by the above-named provider, or at the medical facility, which pertains to my above referenced injury/illness for which I am claiming workers compensation benefits. This release does not authorize the release of information relating to any treatment for a psychological/psychiatric condition, alcohol and drug abuse or HIV/AIDS status.

I understand that I have the right to refuse to sign this authorization.

I understand that I have the right to receive a copy of this authorization and inspect and copy any PHI disclosed pursuant to this authorization.

I understand that I have the right to revoke this authorization. In order to revoke this authorization I may, at any time, send written notification to the above-named hospital/provider. I understand that my revocation of this authorization is ineffective to the extent that the above-named hospital/provider has relied on this authorization to disclose PHI relating to me.

I understand that PHI disclosed pursuant to this authorization may be redisclosed by the person or entity I have identified above and may no longer be protected from disclosure to others by federal or state law. I understand that the above-named hospital/provider may not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to determine a date or event at which time this authorization expires. unless previously revoked by me, this authorization expires one year from the date signed.

I further understand that federal HIPAA law does not require me to provide an authorization in this form as the purpose of this authorization relates to a workers compensation matter.
However, I understand that as a practical matter, my authorization in this form may facilitate the processing and administration of my claim for workers compensation claim for benefits.

A copy of this authorization shall have the same force and effect as an original.

My signature below indicates that I have read and understand this Authorization and its terms.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent, Guardian or Legal Representative, if applicable Date

_____ _____
Witness, if Authorization is signed by someone other than the Patient Date

TO PRIOR PROVIDER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS BY A HOSPITAL/PROVIDER FOR THE PURPOSE OF ADJUSTING A WORKERS COMPENSATION CLAIM FOR BENEFITS

Patient Name:
Date of Birth:
Claim Number:
Date of Injury/Illness:

I, the undersigned, authorize: _____
(HOSPITAL/PROVIDER)

or any health plan, physician, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided treatment to me to release/disclose, in writing, protected health information ("PHI") to:

_____
(PERSON OR ENTITY TO WHOM INFORMATION IS TO BE DISCLOSED)

and its attorneys and/or representatives. The PHI to be disclosed includes medical records and reports, and prescribed medications, relating to my medical treatment/consultation/examination and/or diagnostic procedures performed for prior care and/or treatment which may be relevant in the adjustment of above referenced injury/illness for which I am claiming workers compensation benefits. This release does not authorize the release of information relating to any treatment for a psychological/psychiatric condition, alcohol and drug abuse or HIV/AIDS status.

I understand that I have the right to refuse to sign this authorization.

I understand that I have the right to receive a copy of this authorization and inspect and copy any PHI disclosed pursuant to this authorization.

I understand that I have the right to revoke this authorization. In order to revoke this authorization I may, at any time, send written notification to the above-named hospital/provider or, if unnamed, to the person or entity to whom the information was disclosed. I understand that my revocation of this authorization is ineffective to the extent that any hospital/provider has relied on this authorization to disclose PHI relating to me.

I understand that PHI disclosed pursuant to this authorization may be redisclosed by the person or entity I have identified above and may no longer be protected from disclosure to others by federal or state law. I understand that the above-named hospital/provider may not condition my treatment on whether I provide authorization for the requested use or disclosure.

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Signature of Patient	Date
Signature of Parent, Guardian or Legal Representative, if applicable	Date
Witness, if Authorization is signed by someone other than the Patient	Date