**AUTHORIZATION TO DISCLOSE, RELEASE AND USE**
**PROTECTED HEALTH INFORMATION**
**(HIPAA COMPLIANT)**

To:

This authorization permits you to release a copy of ***any and all*** records in your possession regarding any medical treatment and/or hospitalization of:

**Name of Claimant:**_____ **Date of Birth:**_____

**Social Security Number:**_____

**Date(s) of Injury/Occupational Disease:**_____

By execution of this Authorization I consent that my employer, anyone acting on their behalf including, but not limited to, their insurance carrier, attorney or other representative, shall be permitted to examine and obtain copies of all hospital, medical, educational and vocational records of every sort and kind, review records of any insurance company, interview all doctors, rehabilitation professionals, venders, and all former and subsequent employers regarding all matters relating to any issue relevant my Workers' Compensation Claim.

***I AUTHORIZE*** you to disclose any information and records regarding the above named individual in your possession. This includes but is not limited to, your medical findings, diagnosis, treatment, treatment summaries, psychological or psychiatric evaluations, prognosis, clinic notes, diagnostic reports or radiology films, physical therapy records, pharmacy records, or any other heath information in your records. I understand that based on the information released it may include information related to any substance abuse.

***I UNDERSTAND*** that the information furnished may be used to evaluate and verify my claim for benefits for a work related injury or occupational disease. The information obtained is relevant to a workers' compensation claim(s) and may be used by persons or organizations performing a service related to, or adjudicating the claim(s).

***THIS AUTHORIZATION*** will expire 90 days following a resolution of the workers' compensation claim(s) but may be revoked by signator in writing to the requesting party. Revocation of this authorization will not be valid if the requesting party has taken action in reliance upon such authorization. Please note that the information disclosed or used pursuant to this authorization may be subject to re-disclosure and would, therefore, no longer be protected under the terms of the HIPAA privacy rule.

***A PHOTOSTATIC COPY*** of this authorization shall be deemed to have the same authority as the original.

I hereby certify that I have read the provisions in this authorization. I understand and agree to its terms, and authorize disclosure of the information described above.

_____ _____

Claimant Date

Form E