AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
(HIPAA COMPLIANT)

PARTY AUTHORIZED TO RELEASE INFORMATION

NAME:
_____ADDRESS:_____

PATIENT INFORMATION:

PRINTED NAME:

_____

ADDRESS:

_____

SOCIAL SECURITY NUMBER: _____DOB: _____

TELEPHONE: _____

AUTHORITY TO RELEASE PROTECTED HEALTH INFORMATION:

I hereby authorize you to release the information identified in this authorization form from the medical records of the patient identified above and provide such information **to LUBA Workers' Compensation or designated representative.**

INFORMATION TO BE RELEASED-COVERING THE PERIODS OF HEALTH CARE:

From the date of birth of the patient identified above to four years beyond the date signed below.

TYPE OF INFORMATION TO BE RELEASED:

[X] COMPLETE HEALTH RECORD	[X] DIAGNOSIS & TREATMENT CODES	[X] DISCHARGE SUMMARY
[X] HISTORY & PHYSICAL EXAM	[X] CONSULTATION REPORTS	[X] PROGRESS NOTES
[X] LABORATORY TEST RESULTS	[X] X-RAY REPORTS	
[X] PHOTOGRAPHS/VIDEOTAPES	[X] IMMUNIZATION RECORDS	

[X] OTHER: **VERBAL COMMUNICATIONS BETWEEN THE PARTY AUTHORIZED TO RELEASE INFORMATION AND THE PARTY TO WHOM THE INFORMATION IS RELEASED ARE EXPRESSLY NOT AUTHORIZED AND PROHIBITED**.

PURPOSE OF THE REQUESTED DISCLOSURE OF PROTECTED HEALTH INFORMATION:

TO BE USED IN CONNECTION WITH THE ADMINISTRATION OF WORKERS' COMPENSATION CLAIM

DRUG AND/OR ALCOHOL ABUSE AND AND/OR PSYCHIATRIC, AND/OR HIV/AIDS RECORDS RELEASE:

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing and/or other sensitive information, I agree to its release. [X] YES [ ] NO

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release. [x] YES [ ] NO

RIGHT TO REVOKE AUTHORIZATION:

Except to the extent that action has already been taken in reliance on the authorization, the authorization may be revoked at any time by submitting a written notice to the above named party Authorized to Release Information. Unless revoked, this authorization will expire on the following date, or after the following time period or event: **four years from the date signed below.**

RE-DISCLOSURE:

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE WHO MAY REQUEST DISCLOSURE:

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to the third-party (e.g. fitness for work test), I understand that the services may be denied if I do not authorize the release of information related to such health care services to the third party. I can inspect or copy the protected health information to be used or disclosed**. I hereby release and discharge the above named Party Authorized to Release Information of any liability and the undersigned will hold the above named Party Authorized to Release Information harmless for complying with this Authorization. A COPY OF THIS AUTHORIZATION WILL SUFFICE FOR THE RELEASE OF INFORMATION AND WILL HAVE THE SAME FORCE AND LEGAL EFFECT OF THE ORIGINAL.**

SIGNATURE: _____ DATE: _____

Description of relationship if not patient: _____