## Authorization Form for Release of Records and Information

**COMPLETE SECTION A:**

**A. Employee Identification**
This document authorizes the use and/or disclosure of confidential protected health information about the following person:

Employee Name: _____
Address: _____
City, State, & Zip Code:_____
Employee Date of Birth: _____ Daytime Phone Number: (  ) _____
Employee Social Security Number: _____

**B. Employer Identification**
Employed by:

Employer Name: _____
Address: _____
City, State, & Zip Code:_____

**C. Directions for Release**
This authorization applies in accordance with my directions below, I authorize the release and/or use protected health information pertaining to myself (the employee listed in Section A) to my employer's (as listed in Section B) Workers' Compensation Claims Department.

I authorize the release of all medical records pertaining to my work related injury that occurred on _____ (date), while employed by my employer (as listed in Section B), including but not limited to the purposes of payment and processing of a workers' compensation claim, authorizing and scheduling future medical care, procedures, or therapy, fulfilling prescriptions. I authorize the release of all information except following about me: [Information not to be disclosed if any.]

_____
_____

I understand that the information to be disclosed and/or used may include, but is not limited to information relating to the diagnosis, treatment, health care services provided or to be provided to me, claims records, prior claims information, and patient records, which identifies my name, address, and social security number. I authorize full access including, but not limited to copies of medical records, radiology reports, drug/alcohol screenings, doctor's work status report, medical records, and documents of any kind as they relate to any work-place injury/illness.

I hereby release this information and hold all such medical providers, insurers, TPAs, etc. harmless from the release of this information as set forth in this authorization.

**You Must Continue on the Next Page**

**CHECK ALL THAT APPLY IN SECTIONS B.1a:**

**READ SECTION B:**

**B. Right to Revoke:**
I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire one (1) year after the the closure of my workers' compensation claim. To revoke the Authorization, I understand I must contact the following in writing my employer's (as listed in Section B) Workers' Compensation Claims Department.

**YOU AND A WITNESS MUST SIGN IN SECTION C:**

**C. Authorization and Signature:** I authorize the release of my confidential protected health information, as described within this form. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by Maryland law which prohibits redisclosure or other laws that limit the use and/or disclosure of my confidential protected health information. My treatment, payment, and eligibility are not conditioned on signing this authorization but the information authorized may be necessary for claim review and appeal purposes.

I further understand that failure to sign this may delay, or prevent my workers' compensation claim from being processed, and I may be liable for charges incurred. This form does not confirm any status or acceptance of any workers' compensation claim.

I,_____, have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

_____ _____
Your Signature Date

_____ _____
Signature of Witness Date

_____
Print Name of Witness