Clear Form

AUTHORIZATION FOR THE USE AND DISCLOSURE OF ALL MEDICAL INFORMATION

CLAIM NO: _____

PATIENT/INJURED EMPLOYEE'S NAME: _____

PATIENT/INJURED EMPLOYEE'S ADDRESS: _____

PATIENT/INJURED EMPLOYEE'S TELEPHONE NO: _____

PATIENT/INJURED EMPLOYEE'S DATE OF BIRTH: _____

I, _____ [Injured Employee/Patient or Beneficiary/ Representative of Deceased Injured Employee/Patient listed above] hereby authorize the following medical providers:

Name of Medical Provider	Address
1.	
2.	
3.	
4.	
5.	

to disclose and use the medical information as indicated below concerning medical care rendered to me to:

STATE COMPENSATION INSURANCE FUND

and/or its authorized representatives including but not limited to attorneys, claims adjusters, investigators, and consulting physicians.

Purpose: I understand that the medical information to be furnished pursuant to this medical release may be used or disclosed by State Compensation Insurance Fund only in a manner relating to any claim made by me or on my behalf for workers' compensation benefits in which State Compensation Insurance Fund is the workers' compensation insurance carrier or in any other manner specifically authorized by law.

Duration: This medical authorization shall be valid from the date of signature and shall remain in effect for the duration of the claim, at which time this authorization will expire without any further notice or condition. [California Insurance Code §791.06(g)(2)(B)]

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Revocation: This medical authorization may be revoked in writing at any time prior to the disclosure of information from the health care provider. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received. Any revocation must be sent to State Compensation Insurance Fund, attention: _____ , _____ (state address here)

This medical authorization or its revocation does not effect disclosures that are required or permitted by law without authorization as it pertains to the laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Specify Records to be Used and/or Disclosed:
Please initial and check the box as to the type of information to be used and/or disclosed to State Compensation Insurance Fund

[___] (1) Unless otherwise specified in paragraph (2) below, all Medical Information regarding Patient (as named in this form) is to be used and/or disclosed except for mental health and psychiatric reports and treatment records, Drug/Alcohol information, and Results of HIV tests. This medical information is to include but not limited to general medical information, information and treatment of injury/injuries, medical reports of medical examinations (both inpatient and outpatient), pre-operative and operative reports including discharge summary, x-ray films and interpretation reports, laboratory and pathology test and results.
_____ Initial Here

[___] (2) Specify type of information and records to be disclosed:

_____
_____ Initial Here

Redisclosure: Information disclosed pursuant to this authorization could be re-disclosed by the recipient as permitted by law.

Failure to provide authorization. Note except as otherwise excluded by law and as it pertains to workers' compensation laws and exclusions, treatment or eligibility for workers' compensation benefits will not be conditioned on providing or refusing to provide this authorization.

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I hereby authorize the use and disclosure of my medical information as set forth in this Medical Authorization to State Compensation Insurance Fund and/or its authorized representatives including but not limited to attorneys, claims adjusters, investigators, and consulting physicians.

_____	_____	_____
Signature of Patient/Injured Employee or Beneficiary/Representative of Deceased Patient	Date	Print name and relationship of party signing if other than Patient/Injured Employee

I understand that I have a right to receive a copy of this authorization and I hereby acknowledge receipt of a true copy of this medical authorization.

A carbon copy, photostatic copy or facsimile copy of this true medical authorization shall be as valid as an original of same.

_____	_____	_____
Signature of Patient/Injured Employee or Beneficiary/Representative of Deceased Patient	Date	Name and relationship of party signing if other than Patient/Injured Employee

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Information regarding workers' compensation HIPAA exclusion.

State Compensation Insurance Fund acknowledges the Health Insurance Portability and Accountability Act (HIPAA) requirements medical providers must follow to protect patients' privacy. Workers' compensation is specifically excluded from HIPAA regulations. Because the federal government excluded workers' compensation from HIPAA, we do not anticipate a change in how we obtain medical information from medical providers.

Under Title 45 of the Code of Federal Regulation (CFR), Part 164.512, Section (1), a medical provider may disclose protected health information to State Fund as authorized by and to the extent necessary to comply with laws relating to California's workers' compensation. The law reads as follows:

> "1) **Standard: disclosures for workers' compensation.** A covered entity may disclose protected information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault."

In addition, the Public Health Service Act, Title 42 of the United States Code, Part C, Section 300gg-91(c)(1) "Definitions", states that workers compensation is listed as an excepted benefit and therefore exempt from HIPAA.