Connecticut Neck & Back Specialists, LLC

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AUTHORIZATION TO RELEASE INFORMATION FOR WORKERS' COMPENSATION CLAIMS

Patient Name: _____Date of Birth: _____

The Health Insurance Portability and Accountability Act ("HIPAA") is a federal law that protects employee privacy. It places restrictions on how medical records are distributed. However, workers' compensation claims are exempt from HIPAA rules. The HIPAA Privacy Rule permits the disclosure of your health information for workers compensation purposes without your written authorization.

Although not required by law, we are requesting your written authorization to release information for a Workers' Compensation Claim. The information to be released is limited to the amount that is minimally necessary for the workers' compensation insurer to process the claim and pay for the services rendered.

I hereby authorize **Connecticut Neck & Back Specialists, LLC** to release information from my medical record necessary to process a Workers' Compensation Claim to:

_____ _____
Name of Insurer Address

EXPIRATION DATE:

From (date):____/____/____ To: **End of Treatment**

I understand that I may cancel this authorization at any time, in writing. If the practice has already used this authorization or if this authorization was used so that I could obtain insurance coverage, I may be unable to cancel the authorization. I understand that the practice will not condition treatment or payment based upon my signing this authorization. I am signing this authorization freely. I understand that the information disclosed could be redisclosed by the recipient, and then it is no longer protected by federal regulations. I understand that if the information disclosed is related to HIV/AIDS and/or alcohol/substance abuse that the recipient may not redisclose it under Connecticut State Law. I have reviewed this authorization. I understand it. A copy has been provided to me. I hereby release **Connecticut Neck & Back Specialists, LLC** from any and all liability arising directly or indirectly from disclosure authorized by this consent and any redisclosure of that information.

☐ I permit the release of any of my records related to HIV, Alcohol & Drug Abuse, and psychiatric care.

_____ _____
Signature of Patient/Guardian Relationship to Patient if Signed by Guardian

_____ _____
Date Reason Patient Unable to Sign

_____
Witness:

A copy of this authorization shall be considered as effective and valid as the original.

FOR OFFICE USE ONLY

☐ Reviewed release with Administrator and/or Privacy officer Initials _____
Date_____