



Authorization for Use or Disclosure of Protected Health Information

Patient/Claimant Name: _____ Social Security Number: _____

Date of Birth: _____ State Insurance Fund Claim Number: _____

I hereby authorize the use or release/disclosure of protected health information regarding the above-named individual as described herein. I understand that this authorization is voluntary and made at my direction. I understand that, if the person(s) or organization(s) that I authorize to receive the protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organizations(s) may not be protected by those laws.

1. The following class of person(s) and/or organizations(s) are authorized to disclose the protected health information (as specified below):

- checkbox All Hospitals checkbox All Physicians checkbox All Insurance Companies checkbox Other _____

2. I authorize the following person(s) and/or organization(s) to receive the protected health information.

State Insurance Fund Other: _____
P.O. Box 990004 _____
Boise, Idaho 83799-0004 _____

3. I understand that the purpose for the use or disclosure of the protected health information is to evaluate, assess, validate, process, or administer my workers compensation claim.

4. Specific information to be released/disclosed is as specified:

- checkbox Complete Medical Record checkbox Other _____

5. SPECIFIC AUTHORIZATION: I understand that my health information to be released or disclosed MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature at the bottom of this page authorizes release of all such information, except:

6. I understand that I may revoke this authorization at any time by sending a letter to the person or organization releasing or disclosing the protected health information, except to the extent that information has already been released or disclosed pursuant to this authorization. I understand that I may inspect or copy any information disclosed under this authorization. I understand that the provider may not condition treatment, payment, enrollment or eligibility for benefits upon the execution of this authorization.

7. This authorization expires on: _____

IN THE EVENT THAT NO DATE IS SPECIFIED THIS AUTHORIZATION EXPIRES IN 24 MONTHS.

I have read and considered the contents of this authorization and I confirm that the contents are consistent with my direction.

A photocopy of this authorization shall be valid and shall be accepted with the same effect as the original.

Signature of Patient or Legal Representative Date
(If signed by a Legal Representative, documents to prove authority to sign for patient are attached.)

