The Physician Network
Patient Authorization for Disclosure of Protected Health Information
Workers' Compensation

I, _____(_____), hereby authorize The Physician Network (Network) to
Patient Name *Date of Birth*
disclose my individually identifiable health information for one or more the reasons/purposes described below:

❑ Release all billing and medical information related to this injury to my employer, employer's attorney, employer's worker's compensation insurer, worker's compensation case manager, and the worker's compensation court for Workers Compensation determination

❑ Other_____

❑ I authorize the release of any information that may be included in the above and related to the treatment or diagnosis of drug and alcohol abuse, drug-related conditions, alcoholism, psychological conditions, psychiatric/mental health (with exception of psychotherapy notes) and/or HIV related conditions – ***must be specifically indicated to be released***

For:

❑ All services related to the event/injury on _____

I authorize the following company, organization, and/or person(s) to receive the above information:

Employer/Case Manager/Insurance or Work Comp Carrier for_____ _____
Company/Organization/Insurance Carrier/Case Manager/Worker's Compensation Court *Telephone Number*

_____ _____
Street Address *City* *State* *Zip code* *Facsimile Number*

Prohibition on Condition of Authorization: I understand the Network will not condition treatment on my signing this authorization, unless the only reason the clinic is providing me with health care is to make a report to a third party, such as my employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand information disclosed according to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal law.

Expiration: This authorization for disclosure by the Network will expire once the purpose(s) stated above is served. Where the Network is the recipient, I will be contacted and written authorization obtained for disclosure of my information for additional purposes/reasons beyond those specifically identified above.

Revocation: I understand that I may revoke this authorization at any time by notifying the Network in writing by sending a letter to the manager of the Network clinic at which I receive health care, at the appropriate address listed in the Notice of Privacy Practices. I understand that if I revoke this authorization, it will not affect any actions the Network took before it received my revocation letter. For example, the Network cannot rescind disclosures it has already made (i.e. billing statement previously sent to your employer for payment related to your work injury).

This Authorization is binding. The above statements are binding, controlling and I understand that they take precedence over statements made in the Network's Notice of Privacy Practices. A fax or photocopy of this authorization is valid as the original.

_____ _____
Patient or Personal Representative Signature *Date*

Printed name & relationship of personal representative, if applicable:

_____ _____