Worker's Compensation

Patient Name: ____ Date of Birth: ____________________________

Date of Injury: ____________________________

Employer: ____

Employer's Address: ____

Employer's Phone Number: __________________________________

Employers Worker's Compensation Insurance Information

Insurance Carrier: ____

Address: ____

Phone Number: ____

Claim Number: ____

Please describe below how, when and what time the injury occurred:

____

____

____

____

____

____

Is this the first time one of our providers have seen you for this injury? ____________________

If not, please explain: ____

____

I understand that my workman's compensation claim will be filed though my employer/employer's workers compensation insurance carrier as stated above on this form and any subsequent work-related injuries that we are advised of. In the event it is determined by the Worker's Compensation Court that the illness or condition stated above is not a result of a work-related injury, I do herby agree to pay for all services rendered.

Patient Signature:____Date:___________________

Relationship: ____

Saline Medical Specialties

Patient authorization for Disclosure of Protected Health Information Workers' Compensation

I, ______________________________ (______________) herby authorize Saline Medical Specialties to disclose

(Patient Name) (Date of Birth)

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 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 of Condition of Authorization: I understand *Saline Medical Specialties* 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 *Saline Medical Specialties* will expire once the purpose(s) stated above is served. Where *Saline Medical Specialties* is the recipient, I will be contacted and written authorization obtained for disclosure of my information for addition purposes/reasons beyond those specifically identified above.

Revocation: I understand that I may revoke this authorization at any time by notifying *Saline Medical Specialties* in writing by sending a letter to the manager of *Saline Medical Specialties* 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 *Saline Medical Specialties* took before it received my revocation letter. For example, *Saline Medical Specialties* 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 *Saline Medical Specialties* Notice of Privacy Practices. A fax or photocopy of this authorization is valid as the original.

Patient or Personal Representative Signature: ______________________________ Date: ____________

Printed Name and relationship of personal representative, if applicable: ______________________________