UNIVERSITY OF WISCONSIN SYSTEM
OFFICE OF RISK MANAGEMENT
WORKER'S COMPENSATION PROGRAM

Authorization to Use or Disclose Health Information to Worker's Compensation Self-Insurer

Injured Employee:

Worker's Compensation Claim Number:

Date of Birth:

Authorization Expiration Date: **UNTIL WORKER'S COMPENSATION CASE IS CLOSED.**

1. I authorize the release of medical information created prior and after the date of my signature to University of Wisconsin System or their representatives at the State of Wisconsin.

2. I authorize any health care providers/physicians/ psychologists/psychiatrists to provide record copies.

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. The information identified above may be used by or disclosed to my Worker's Compensation self-insurer, the University of Wisconsin.

5. This information for which I'm authorizing disclosure will be used for management of my worker's compensation claim.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the University of Wisconsin System. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my Worker's Compensation self-insurer, the University of Wisconsin System, when the law provides the System with the right to contest a claim.

7. I understand that by claiming worker's compensation I waive the usual practitioner-patient privilege and my personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal privacy laws or regulations. My personal health information may be released to any of the following: the employer, the worker's compensation insurer, the Department of Workforce Development, other parties to this matter of their attorneys; the Labor and Industry Review Commission; any court on any action or proceeding relating to this matter; experts retained or consulted by any party; and any of their agents, employees, or representatives. I specifically authorize and consent to any such disclosure and redisclosure.

8. I understand that the health care provider may not condition my treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purposes of creating protected health information for disclosure to a third party.

9. This consent or photostatic copy of this authorization shall be as valid and effective as the original.

Signing this document will expedite the investigation of your claim and consideration of your receiving benefits. You may refuse to sign this document. However, this could delay the investigation of your claim, and may result in suspension of worker's compensation benefits.

_____ _____

Signature of injured employee or legal representative Authorization Date

_____

(If signed by legal representative, relationship to employee)

MEDICAL PROVIDER LIST

MEDICAL PROVIDER NAME____

CLINIC NAME____

ADDRESS____

PHONE NUMBER____

TREATMENT DATES____

MEDICAL PROVIDER NAME____

CLINIC NAME____

ADDRESS____

PHONE NUMBER____

TREATMENT DATES____

MEDICAL PROVIDER NAME____

CLINIC NAME____

ADDRESS____

PHONE NUMBER____

TREATMENT DATES____

MEDICAL PROVIDER NAME____

CLINIC NAME____

ADDRESS____

PHONE NUMBER____

TREATMENT DATES____

PLEASE USE THE BACK SIDE OF THIS FORM OR ANOTHER PIECE OF PAPER FOR ADDITIONAL MEDICAL PROVIDERS.

Return Forms To: **University of Wisconsin System Administration**
Office of Risk Management
780 Regent St.
Madison, WI 53715-2635