AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Claimant: _____
Last Name First Name Middle Initial

Injury Date: _____ Date of Birth: _____

Former Name (if applicable) _____

Employer: ***UNIVERSITY OF TOLEDO AND/OR UNIVERSITY MEDICAL CENTER***

I, the above-named injured worker, understand I am allowing all past and future medical care and psychological/psychiatric providers (persons or facilities) that attend, treat, or examine me to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers' compensation claim:

Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other:

_____

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio (IC), my employer, my employer's managed care organization (MCO), my employer's authorized representative(s).

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers' compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers' compensation claim remains open under Ohio law. However, I understand I have the right to revoke this authorization at any time, but my revocation must be submitted in writing and filed with BWC or my employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand that providers may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include, but are not limited to, the following:

- A copy of the medical information the employer receives may be forwarded to BWC by the employer.
- A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

_____ _____
Claimant (or guardian or personal representative) signature ***Date***

If signed by the injured worker's guardian or personal representative, provide here a description of the guardian:

A PHOTOCOPY OF THIS RELEASE SHALL BE EFFECTIVE AS THE ORIGINAL

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.