



Medical Release Authorization

We request that you complete the below information for purposes of providing a complete medical history to the evaluating physician(s) your claim for workers' compensation benefits. Please complete this form fully and accurately. We have also attached herewith a Medical Release for your signature.

It is important that you complete both forms, attach your signature and the date, then return them both to our office within 5 working days. Failure to do so may interfere with our right to obtain substantial medical evidence for the determination of compensability of your claim, and therefore, may jeopardize your potential right to workers' compensation benefits.

"During the past five (5) years I have received medical treatment at the following locations".

NAME	FULL ADDRESS (street name, city, state, zip)	PHONE NUMBER	MONTH/YEAR
1.			
2.			
3.			
4.			
5.			

This will authorize you to permit Intercare Holdings Insurance Services or their agent to review, inspect, copy and/or photocopy any and all of the following which are in your possession or control:

1. X-rays, films, medical reports, charts, graphs and notes.
2. Personnel, attendance, employment, and wage records of employer or school, including any and all records of earnings and employment from the Social Security Administration.
3. Any and all insurance claims file for the undersigned dealing with prior, present, or subsequent claims for injuries and/or damages.

The above medical information may be used by Intercare Holdings Insurance Services for any and all purposes pertaining to or arising out of the claim by the undersigned.

This authorization shall remain valid until the above-referenced claim has been finalized, but in no event longer than six (6) years from the date below.

I understand that I have the right to receive a copy of this authorization.

Photostat copies of this authorization shall be considered as valid as the original.

Date: _____

Signed: _____

Authorization for Use or Disclosure of Protected Health Information

I hereby authorize the use or disclosure of my medical information (also known as protected health information) as described below.

1. I, _____, authorize all persons or entities who provided medical treatment to me for injuries I received on _____ to disclose the following medical information in your possession to Intercare Insurance, its employees, agents, subcontractors and authorized representatives ("Intercare Insurance").
2. Please provide Intercare Insurance with any and all information in your possession concerning my healthcare history, diagnosis, condition, treatment or evaluation related to injuries I received on _____ so that they may use it or disclose it to evaluate, administer and resolve my claim related to such injuries. I understand that the medical information that is disclosed may include information relating to sexually transmitted disease(s), 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.
3. This authorization shall be in force and effect until my claim related to injuries I received on _____ is resolved, at which time this authorization to use or disclose this protected health information expires. I understand that I may revoke this authorization by notifying the Adjuster handling the claim in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by Intercare or the Releasing Party in reliance on it before I revoked it.
4. As the person signing this Authorization for Release of Protected Health Information, I understand that I am giving permission to Intercare to obtain and use protected health information. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
5. A copy of this authorization may be accepted with the same authority as the original.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

NOTICE TO PROVIDERS

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) and the privacy regulations issued to implement it, a covered entity (health care provider, including, but not limited to, physician, hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or hospice program) can release an employee's protected health information (PHI) "as authorized and to the extent necessary to comply with laws relating to workers compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault." 45 CFR 164.512(l). Intercare Holdings Insurance Services, is a third party administrator handling workers compensation claims on behalf of your employer. Please provide us with the appropriate medical records and information related to the individual identified on the attached document.

DISCLOSURE OF LC4663(d) & PHYSICIAN LIST

NAME :
INJURY DATE :
CLAIM NO. :

PER L.C. SECTION 4663(d): AN EMPLOYEE WHO CLAIMS AN INDUSTRIAL INJURY SHALL, UPON REQUEST, DISCLOSE ALL PREVIOUS PERMANENT DISABILITIES OR PHYSICAL IMPAIRMENTS:

PLEASE LIST ALL YOUR PREVIOUS PERMANENT DISABILITIES OR PHYSICAL IMPAIRMENTS:

Please list all the doctors that you have treated with over the past five (5) years.

PLEASE INDICATE ADDRESSES.

Name and address of Medical Provider Treatment Dates Diagnosis

1) _____

2) _____

3) _____

4) _____

5) _____
