# WORKERS' COMPENSATION COMMISSION

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

***PURSUANT TO COMAR 14.09.03.07 REQUIRING THE DISCLOSURE OF MEDICAL INFORMATION IN A WORKERS' COMPENSATION CLAIM***

TO: _____
(Name of Record Holder)

| PATIENT/CLAIMANT NAME | Social Security Number | DATE OF BIRTH |
|---|---|---|
| | | |

I, hereby, authorize you to give to:

_____
(Name of Record Requestor)

a copy of all information developed by you in my medical record regarding the condition of the following part or parts of my body or my medical condition:

(Specify part or parts of body or medical condition.)

while under your observation or treatment or otherwise in your possession. This includes, but is not limited to, history, findings, office and patient charts and files, examination and progress notes, physical evidence prepared by you and any subsequent or future developments relating to my health or mental condition. ***This authorization is valid for up to one year from the date it is signed. I understand that I may revoke this authorization in writing at any time.***

Disclosure of medical information pursuant to this authorization is **NOT** prohibited under the **Health Insurance Portability and Accessibility Act** ("HIPAA").

**The Health Insurance Portability and Accessibility Act** (" HIPAA" ) at 45 CFR sect. 164.512 provides: " a covered entity may disclose protected health information as authorized by 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 illnesses without regard to fault."

_____
SIGNATURE of claimant/patient or authorized representative

_____
DATE

**10 East Baltimore Street • Baltimore, Maryland 21202-1641**
**410-864-5100 • Email: info@wcc.state.md.us • Web: http://www.wcc.state.md.us**