Form 308 I

AUTHORIZATION TO DISCLOSE, RELEASE AND USE PROTECTED HEALTH INFORMATION (HIPAA COMPLIANT)

PLEASE PRINT OR TYPE

Requesting Party _____ **Telephone Number** _____
Address _____
_____ **Fax** _____

TO _____ (Medical Providers as listed on Form 307)
_____

This authorization permits you to release a copy of records in your possession regarding any medical treatment and/or hospitalization of:

Name of Patient _____ **Date of Birth** _____

Social Security Number _____

Date(s) of Injury/Occupational Disease _____

I AUTHORIZE you to disclose any information and records regarding the above named individual in your possession. This includes but is not limited to, your medical findings, diagnosis, treatment, treatment summaries, prognosis, clinic notes, diagnostic reports or radiology films, physical therapy records, pharmacy records, or any other health information in your records for the past 10 years (15 years if claim is being adjudicated). I understand that based on the information released it may include information related to any substance abuse.

I UNDERSTAND that the information furnished may be used to evaluate and verify my claim for benefits for a work related injury or occupational disease. The information obtained is relevant to a workers' compensation claim(s) and may be used by persons or organizations performing a service related to, or adjudicating the claim(s).

THIS AUTHORIZATION will expire 90 days following a resolution of the workers' compensation claim(s) but may be revoked by signator in writing to the requesting party. Revocation of this authorization will not be valid if the requesting party has taken action in reliance upon such authorization. Please note that the information disclosed or used pursuant to this authorization may be subject to re-disclosure and would, therefore, no longer be protected under the terms of the HIPAA privacy rule.

A PHOTOSTATIC COPY of this authorization shall be deemed to have the same authority as the original.

I hereby certify that I have read the provisions in this authorization. I understand and agree to its terms, and authorize disclosure of the information described above.

_____ _____
Patient Date

Please fax or mail back to the requesting party at the above fax/address.

Official Form 308 I
State of Utah ● Labor Commission ● Division of Industrial Accidents
160 East 300 South● P.O. Box 146610 ● Salt Lake City, UT 84114-6610 ● Telephone: (801) 530-6800
Fax: (801) 530-6804 ● Toll Free: (800) 530-5090 ● www.laborcommission.utah.gov