MD WORKERS' COMPENSATION COMMISSION AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Authority COMAR 14.09.03.07B: Unless the Commission orders otherwise for good cause shown, a party shall provide to any other party, on written request, a medical authorization or release.

A. Person Covered by Authorization This document authorizes the disclosure of protected health information regarding:

Name/Claimant _____ Date of Birth _____

B. Purpose of Disclosure

This document authorizes the disclosure of protected health information for the purpose of processing, adjudicating and resolving workers' compensation claims.

C. Entities Authorized to Make Disclosure

This document authorizes any health plan, physician, health care professional, dentist, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf to disclose my protected health information consistent with this directive.

D. Entities Authorized to Receive Protected Health Information

This document authorizes the disclosure of my protected health information to the following entities and their agents: my attorney, my employer, my employer's workers' compensation insurer, the Uninsured Employers' Fund and the Subsequent Injury Fund.

E. Information to be disclosed This document authorizes the entities listed in C to disclose protected health information that is relevant to:

1. The member of the body that was injured:
2. The description of how the accidental injury occurred:
3. The description of how the occupational disease occurred:

The protected health information that may be disclosed includes, but is not limited to: history, findings, office and patient charts, files, examination and progress notes, and physical evidence.

F. I understand that I may revoke this authorization by giving written notice to all parties to my claim for workers' compensation, except to the extent that this authorization has already been acted on prior to receipt of my revocation.

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient to a medical manager, health care professional or registered rehabilitation practitioner, and others consistent with state and federal law.

By signing this form, I am authorizing the disclosure of my protected health information. This authorization is valid for one year from the date this form is signed.

Patient/Claimant Signature: _____ Date: _____

A photocopy, facsimile or electronic transmission of this signed authorization form is valid.

CLICK HERE TO CLEAR THIS FORM