WORKER'S COMPENSATION

RELEASE OF MEDICAL RECORDS AUTHORIZATION

By law, all health care providers must provide any employee, employer, worker's compensation insurer or their representative any information reasonably related to any alleged work injury. However, determining the relationship of prior medical records to a work injury can be difficult and time consuming. Therefore, to assist in the timely investigation of your claim, this document authorizes the health care provider to release medical information without attempting to determine the extent of its relationship to your alleged work injury:

NAME OF PROVIDER:			
PROVIDER ADDRESS:			
PHYSICIAN:		**EMPLOYER NAME:**	GREEN COUNTY
PATIENT NAME:		**PATIENT D.O.B.:**	
PATIENT SSN:		**WC CLAIM NO.:**	

The patient named above hereby authorized the health care provider named above to disclose all records checked below in its possession relating to the patient's health, treatment, and evaluation to:

NAME & ADDRESS OF PARTY AUTHORIZED TO RECEIVE PROTECTED INFORMATION:	Aegis Corporation 18550 West Capitol Drive Brookfield, WI 53045

or its designated representatives, and to furnish to them a legible, certified duplicate of all records, writings, reports, test results and x-rays in its possession containing such information. This authorization includes all records, reports, correspondence, or other materials in the possession of the health care provider authorized, even if those materials were not generated by the health care provider, and the redisclosure of such materials is hereby authorized. This release is for use in the investigation, preparation, evaluation, and/or hearing of the worker's compensation claim described above.

PHYSICAL ONLY:
Release all records, correspondence, and any other information from whatever source regarding the patient's physical health, treatment and evaluation including, but not limited to, any made or provided by any physician, nurse, chiropractor, osteopath, dentist, physical therapist, hospital, or ay other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited to Wis. Stat. §§ 51.30, 146.025, 146.81, and 146.82, 42 C.F.R., Chap. 1, subpart C., § 2.31 and 45 C.F.R. § 164.508.

In signing this consent form, I acknowledge that I understand that:

- I am authorizing release of the records and information listed above.
- I am waiving any privilege that may otherwise prevent disclosure of the records and information listed above.
- I understand that the health care provider named above, whom I am authorizing to disclose my protected health information, may not condition my treatment, payment,enrollment or eligibility for benefits (if applicable) on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
- I may revoke this authorization at any time by a written request to the party authorized above to receive information, except that the party authorized above to receive such information may rely upon any personal health information received before the revocation of this authorization. Any by notifying the disclosing medical records/health information department in writing.
- I may obtain a copy of the disclosed medical records and information, upon written request to the party authorized above to receive information, at no charge to me.
- My personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal law. My personal health information may be released to any of the following: the employer, the worker's compensation insurer, the Department of Workforce Development, other parties to this matter or their attorneys; the Labor and Industry Review Commission; any court on any action of proceeding relating to this matter; experts retained or consulted by any party; and any of their agents, employees, or representatives. I specifically authorize and consent to any such disclosure and redisclosure.
- I am entitled to a copy of this consent form after I sign it.

This consent is subject to revocation at any time. If not revoked, this consent is effective for two (2) years from date signed. This authorization expressly waives any requirement that is must be used within a certain number of days after the date of signing, or that is must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. A photocopy shall be valid as the original.

PATIENT SIGNATURE (OR PERSON AUTHORIZED TO SIGN FOR PATIENT):	**DATE:**