

**AUTHORIZATION TO USE AND DISCLOSE  
HEALTH INFORMATION FOR WORKER'S COMPENSATION**

*If the information is about a Mental Illness, Developmental Disability, HIV/AIDS Testing or Treatment, Communicable Disease, Venereal Disease, Alcohol or Drug Abuse, Abuse of an Adult with a Disability, Sexual Assault, Child Abuse or Neglect, or Genetic Testing, then the patient must sign the Specific Consent Attachment.*

***A patient label may be placed here:***

**Patient's Name:** \_\_\_\_\_  
Last First Middle

**Medical Record Number:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**Home Telephone:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

The UC Organized Health Care Arrangement (or **UC OHCA**) consists of University of Chicago Hospitals, certain activities of the University of Chicago including the physicians, the UCHHS Regional Doctors Offices, and Friend Family Health Care Clinic in Hyde Park.

\*\* Each of these is called a **UC Organization**.

**PURPOSE:** By signing this Authorization, I will allow the UC Organizations to disclose the health information listed below for the following purpose(s):

- Worker's compensation review and claim processing and adjudication.
- Other (*specify*): \_\_\_\_\_.

**SPECIFY INFORMATION TO BE DISCLOSED:** The information that may be disclosed under this Authorization includes:

- All of my health information maintained by any UC Organization.
- The results of any services required by employer for the worker's compensation review and claim processing and adjudication.
- The following (*specify*): \_\_\_\_\_.

**RECIPIENT:** The following is the name and address of the person or the class of persons (e.g. HR Director; worker's compensation carrier; my attorney) to whom the UC Organizations may disclose the health information:

\_\_\_\_\_  
\_\_\_\_\_.

*I understand that the University of Chicago Hospitals may be paid for the services by ???, but it will not, directly or indirectly, receive any other items of value from any third party in connection with the use or disclosure of the health information.*

**TERM:** This Authorization will remain in effect:

- From the date of this Authorization until the following date: \_\_\_\_\_, 200\_\_.
- Until the purpose is fulfilled.
- Until the following occurs (e.g. *if I write to UCH stating that I am no longer covered by worker's compensation*):

- \_\_\_\_\_  
 Other (e.g. no expiration): \_\_\_\_\_.

*Note: The Term for mental health records must be stated—you may not use "no expiration."*

**\*Provide a copy of signed Authorization to Patient**

**I UNDERSTAND THAT IF I DO NOT SIGN THIS AUTHORIZATION, UCH MAY DETERMINE THAT IT CANNOT DISCLOSE THE HEALTH INFORMATION, AND THE EMPLOYER MAY NOT PROVIDE CERTAIN BENEFITS. I CAN ASK THE EMPLOYER ABOUT THE CONSEQUENCE OF UCH NOT PROVIDING THE HEALTH INFORMATION. UNIVERSITY OF CHICAGO HOSPITALS CANNOT PROVIDE ME WITH THIS INFORMATION.**

**I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. IF THE PURPOSE OF THE SERVICES IS TO PROVIDE HEALTH INFORMATION FOR WORKER'S COMPENSATION REVIEW AND CLAIM PROCESSING AND ADJUDICATION, THEN UCH MAY REFUSE THESE SERVICES. IF THE TREATMENT IS RELATED TO PARTICIPATION IN A RESEARCH STUDY, I UNDERSTAND THAT A UC ORGANIZATION MAY REFUSE TREATMENT IF I DO NOT SIGN THIS AUTHORIZATION.**

I understand that once the health information is disclosed to the recipient, neither UCH nor any of the other UC Organizations can guarantee that the recipient will not redisclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or applicable federal and Illinois law governing the use and disclosure of the health information.

I may inspect or copy any information used/disclosed under this Authorization.

I understand that I may change my mind and revoke this Authorization in writing at any time by notifying the Privacy Office (see the information below). Changing my mind may affect the services I receive, as stated above. The revocation will not apply to the extent that any UC Organization has already taken action where it relied on my permission.

I have read and understand the terms of this Authorization and I have had a chance to ask questions about the use and disclosure of the health information. I authorize each UC Organization to use or disclose the health information in the manner described above.

\_\_\_\_\_  
*Signature of Patient or Personal Representative\**

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Name of Personal Representative\* (if applicable)*

\_\_\_\_\_  
*Relationship to Patient*

*\* The Personal Representative is the patient's decision maker. It can be the parent if the patient is a minor, legal guardian, health care surrogate, or other person.*

**UC OHCA Privacy Office: University of Chicago Medical Center, MC-1000, 5841 South Maryland Avenue, Chicago, IL 60637, Telephone Number: (773) 834-9716**

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