



Form Instructions

Please complete as much information as you have available. If you need help completing the form, contact Claims at (208) 332-2100 or (800) 334-2370.

Please save a copy for your records.

Submission options:

- **Upload** at <https://hub.idahosif.org/Document/Upload>
- **Email** as an attachment to: ClaimsIM@IdahoSIF.org
- **Mail to:**
SIF, Idaho Workers' Compensation
P.O. Box 83720
Boise, ID 83720-0044

Note: Mistakes happen, if you spot or realize an error, please contact us and we will work with you to sort things out. Please be aware that any person who knowingly, and with intent to defraud or deceive any insurance company, submits a statement or claim containing any false, incomplete, or misleading information is violating the law.



Authorization for Use or Disclosure of Protected Health Information (Medical Release Authorization)

Patient/Injured Worker:

Claim #:

Date of Birth:

I hereby authorize the use or release/disclosure of protected health information regarding the above-named individual as described herein. I understand that this authorization is voluntary and made at my direction. I understand that, if the person(s) or organization(s) that I authorize to receive the protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organizations(s) may not be protected by those laws.

1. The following class of person(s) and/or organizations(s) are authorized to disclose the protected health information (as specified below):

- checkbox All Hospitals, checkbox All Physicians, checkbox All Insurance Companies, checkbox Other

2. I authorize the following person(s) and/or organization(s) to receive the protected health information.

SIF, Idaho Workers' Compensation
Other: P.O. Box 990004
Boise, Idaho 83799-0004

3. I understand that the purpose for the use or disclosure of the protected health information is to evaluate, assess, validate, process, or administer my workers compensation claim.

4. Specific information to be released/disclosed is as specified:

- checkbox Complete Medical Record, checkbox Other

5. SPECIFIC AUTHORIZATION: I understand that my health information to be released or disclosed MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature at the bottom of this page authorizes release of all such information, except:

6. I understand that I may revoke this authorization at any time by sending a letter to the person or organization releasing or disclosing the protected health information, except to the extent that information has already been released or disclosed pursuant to this authorization. I understand that I may inspect or copy any information disclosed under this authorization. I understand that the provider may not condition treatment, payment, enrollment or eligibility for benefits upon the execution of this authorization.

7. This authorization expires on:

IN THE EVENT THAT NO DATE IS SPECIFIED THIS AUTHORIZATION EXPIRES IN 24 MONTHS.

I have read and considered the contents of this authorization and I confirm that the contents are consistent with my direction.

A photocopy of this authorization shall be valid and shall be accepted with the same effect as the original.

Signature of Patient or Legal Representative Date
(If signed by a Legal Representative, documents to prove authority to sign for patient are attached.)

