IDAHO WORKERS' COMPENSATION

Authorization for Use or Disclosure of Protected Health Information

Patient/Injured Worker: _____ Social Security Number: _____

Date of Birth: _____ Claim Number: _____

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):

☒ All Hospitals ☒ All Physicians ☒ All Insurance Companies

☐ Other _____

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

SIF, Idaho Worker's Compensation
P.O. Box 990004 Boise, Idaho
83799-0004

Other: _____

_____

_____

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:

☐ Complete Medical Record ☐ 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.)

PO Box 83720 • Boise, ID 83720-0044 • 208-332-2100 • www.idahosif.org

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Claim number: _____

Patient/Injured Worker name: _____

Please list the names, addresses, and phone numbers of all the doctors you have seen and medical facilities you have used in the past ten years.

DATE	PHYSICIAN AND/OR MEDICAL PROVIDER	ADDRESS	PHONE

Submit by one of these methods:

Upload completed/signed form to our website at: www.idahosif.org/document/upload
Email as an attachment to: claimsim@idahosif.org
Fax to: 208-332-2171
Mail to: SIF, Idaho Workers' Compensation; PO Box 990004; Boise, ID 83799-0004