AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION, INSURANCE, AND/OR EMPLOYMENT RECORDS

TO:

RE: Claimant:
Claim No:
Social Security No.:
Date of Birth:

Patient authorization: I hereby authorize the entity listed above to disclose my protected health information defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) including: any and all industrial and non-industrial medical records and reports; intake forms, diagnostic imaging studies and reports; photographs; psychiatric testing, reports and records; psychological testing, reports and records; prescriptions; correspondence; phone messages; bills and statements of charges; payments and insurance records; and entire hospital records including diagnostic imaging studies and specimen slides. In addition, I authorize the release of any and all records from other providers that are contained in my medical chart.

I further authorize release of information from any employer or educational institution about my earnings, loss of earnings, work history, enrollment, academic performance, and medical information in their possession.

I further authorize the Industrial Commission of Arizona to release a copy of the complete claim files maintained by the Industrial Commission of Arizona concerning my workers' compensation claims, including drug, alcohol, and/or psychiatric records to CopperPoint Insurance Company. I further, as to this request only, hereby waive any right to privacy and confidentiality regarding these claim files.

I also authorize the entity listed above to release its entire claim file containing records, including medical information, related to previous or pending workers' compensation or personal injury claims filed by the above listed individual.

This authorization approves the release of records containing information related to the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, behavior or mental health services, and/or psychiatric treatment. I give my specific authorization for these to be released.

This release does not permit direct communication with the health care provider. This release is an authorization to obtain documents only.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Specific description of information to be disclosed: All documents listed above.

Purpose of Release: The purpose of the disclosure is to allow CopperPoint Insurance Company a workers' compensation insurance carrier, to administer benefits and to have a proper understanding of a workers' compensation claim and to determine the respective rights of CopperPoint Insurance Company and the undersigned under the Arizona Workers' Compensation Act, as provided pursuant to A.R.S. § 23-908(D). **I further acknowledge that such purpose is a use and disclosure for which consent, authorization, or opportunity to agree or object is not required, pursuant to HIPAA Regulations, 45 C.F.R. § 164.512 (l), which provides as follows:**

> Uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required.
>
> (l) Standard: disclosures for workers' compensation.

A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Information released to: CopperPoint Insurance Company
3030 N. 3rd Street
Phoenix, AZ 85012

Right of Revocation. I understand that I have the right to revoke this authorization at any time, provided that my revocation is in writing. I understand that my revocation will be effective upon its receipt by the person(s) I authorized above but would not be effective to the extent that such persons have acted in accordance with this Authorization and in reliance thereon. With respect to the person(s) I authorized to receive and use health information, if patient (or personal representative) requested this Authorization, any revocation will be effective only when I communicate my revocation directly to them. I understand that revocation of this authorization does not limit the above-referenced insurance carrier's right to receive medical records to gain a proper understanding of a worker's compensation case pursuant to A.R.S. § 23-908(D).

Re-disclosure. I understand that if the recipient of my information is not a health care provider, a health plan or health care clearing house or not an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such recipient and my information may no longer be protected by state and federal laws. If this Authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the substance abuse information under federal substance abuse confidentiality requirements.

Automatic two-year duration. This authorization will automatically expire after two (2) years from the date of signing unless you specify a different expiration date as follows:

Right to Refuse to Sign. I understand that I do not have to sign this authorization and that my failure to sign this authorization will not affect my ability to obtain treatment, payment, or benefits.

I agree that a photocopy of this authorization may be used for all purposes the same as the original.

Date: _____ _____

[APPLICANT NAME]
or Authorized Representative