UPMC WorkPartners
Providing Health & Productivity Solutions

SELF-FUNDED WORKERS' COMPENSATION MEDICAL AUTHORIZATION

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of my protected health information (PHI) relevant or potentially related to the injury indicated below to UPMC Benefit Management Services, Inc., d/b/a UPMC WorkPartners ("WorkPartners"), its successors, or any of its authorized representatives (including attorneys working on its behalf) by all applicable medical practitioners, hospitals, other medical or medically related facilities, pharmacies, claims administrators, and insurers, including, but not limited to, those who administer Group Health, Short-Term Disability, Long-Term Disability, Workers' Compensation, Health and Wellness, Family Medical Leave, Disease Management, and rights under the Americans with Disabilities Act pursuant to my application for Workers' Compensation benefits.
Date of Injury:______________________

Such disclosure may contain information related to my Workers' Compensation medical condition or other condition(s) noted below, including, but not limited to, diagnosis, prognosis, progress notes, diagnostic and laboratory tests, treatment plan, prescriptions, wages, or earnings. I specifically acknowledge that the PHI released pursuant to this authorization may include behavioral health records, chemical dependency/substance abuse records, and/or HIV treatment records, only where such information is relevant to my application for Workers' Compensation benefits.
Specify medical information to be released:________________________________

I further authorize WorkPartners to disclose any and all facts related to my injury, illness, or disability to my employer-contracted benefit administrators or insurers (including health benefits provider(s); claims processors; case, disease, or health management companies, and insurers) to determine eligibility for health or disease management programs and for administration and operations of employer benefit plans (including, but not limited to, Short-Term Disability, Long-Term Disability, Workers' Compensation, coordination of care and quality assurance, health improvement, and utilization review programs).

I understand information received pursuant to this authorization may be used by WorkPartners for the investigation and determination of any applicable Workers' Compensation benefits to which I may be entitled. I understand that payment for treatment and benefits may be conditioned upon this authorization; I also understand that my health care provider will not condition my treatment based on this authorization. I understand this authorization is valid for the duration of my claim for Workers' Compensation benefits and up to the maximum period allowed by law.

IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have a right to receive a copy of this authorization. I may revoke this authorization at any time before its expiration date by notifying WorkPartners in writing, but the revocation will not have any effect on any actions taken before the revocation was received by WorkPartners. I understand that any of my PHI received by WorkPartners may be released to others in accordance with the terms of this authorization. Re-disclosure of my PHI by WorkPartners or any other party is not protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

PERSONAL INFORMATION

First Name: ____________________________________ Last Name: ____
Street Address: _________________________________ City, State, and Zip: _________________________________
Telephone: ____________________________________ Date of Birth: ____
Employee Number: ______________________________ Employer Facility and Department: __________________________

I certify that all of the information is, to the best of my knowledge, true, correct, and complete.

Please fill in the information requested above and sign and return this form by fax to 412-667-7100 OR by mail to WorkPartners, PO Box 2971, Pittsburgh, PA 15230.

Employee Signature: ______________________________ Date Signed:_____________________________

Name of Personal Representative:____

Signature of Personal Representative:____

Authority to sign on behalf of the Employee:____

(Please submit documentation of designation status or explanation why designation is needed.)

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