UPMC WorkPartners
Providing Health & Productivity Solutions

SHORT-TERM DISABILITY MEDICAL AUTHORIZATION

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of my protected health information (PHI) relevant or potentially implicated in the disability(ies) in question to UPMC Benefit Management Services d/b/a WorkPartners, its successors, or any of its authorized representatives 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 Short-Term Disability benefits. The specific disability(ies) at issue and the records/documents being sought are identified on the accompanying cover sheet.

Such disclosure should contain information related to my medical condition(s) and/or disability(ies), including, but not limited to, diagnoses, prognosis, progress notes, diagnostic and laboratory tests, treatment plan(s), 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 Short-Term Disability benefits.

I further authorize WorkPartners to disclose any and all facts related to my disability(ies) to my employer, employer-contracted benefit administrators or insurers (including health benefits provider(s); claims processors; and 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 to determine my eligibility for benefits or compensation to which I may be entitled under any benefit plan or practice of my employer, which requires evaluation for physical or mental condition, including, but not limited to, a leave from work for medical reasons. 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 disability 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 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. **I acknowledge that failure to complete this authorization or subsequent revocation of the authorization set forth herein may impact my ability to receive disability benefits.**

Please fill in the information requested above and sign and return this form by fax to 412-667-7090 OR by mail to WorkPartners, PO Box 2973, 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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