

AUTHORIZATION TO OBTAIN INFORMATION
AND DISCUSS BILLING ISSUES

Name: _____ UIN#: _____

Telephone Number: () _____ Date of Birth: _____

I hereby authorize any licensed physician, medical practitioner, pharmacist, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment, causation, prognosis and billing with respect to my alleged work-related injury to give any and all such information to my employer, University of Illinois ("U of I") Office of Workers' Compensation and Claims Management to which I am submitting a claim, in order to fully investigate my claim for workers' compensation benefits. **This authorization also allows the U of I Office of Workers' Compensation and Claims Management to discuss any and all billing issues with my medical provider(s) and their representatives.**

I understand that pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), a covered entity may disclose protected health information (PHI) 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 illnesses without regard to fault. I further understand that the medical information relating to my workers' compensation claim and received by U of I, in capacity of employer, does not constitute protected health information.

I understand the information obtained by use of this authorization may be used by U of I, its rehabilitation/medical management nurses, vocational counselors, examining medical practitioners and legal representatives to determine eligibility for workers' compensation benefits. U of I, its administrators, rehabilitation/medical management nurses, vocational counselors, examining medical practitioners and legal representative may forward information

pertaining to my job requirements to any medical practitioner rendering treatment to me when said information is germane to the diagnosis, treatment, causation and prognosis of my physical or mental condition.

I know that I am entitled to a copy of this authorization.

I agree that a photographic copy of this authorization shall be as valid as the original.

I agree this authorization shall be valid from the date of my alleged injury and through the pendency of my workers' compensation claim.

I agree that this authorization may only be revoked in writing. However, such a revocation will not be effective for uses or disclosures that have already been made, or other actions that have already been taken, in reliance on this authorization or as required by law.

I understand that there is potential for the protected health information to be re-disclosed by recipient and no longer protected under HIPAA.

I understand that my failure to sign this document may result in the delay of payment of workers' compensation benefits due to my employer's inability to obtain medical records pertaining to my claim for benefits.

Signature

Printed name

Date

6/09

(Rev. 2/10)

List of Physician Providers / Treatment Facilities

Name: _____ UIN: _____

My first day of treatment for this condition was/will be: ____/____/____

Please list the names, addresses, zip code, phone and fax numbers for medical providers and treatment facilities. In an effort to process your claim efficiently, the following information is **required**.

Medical Provider: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Treatment Facility: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Medical Provider: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Use additional sheets of paper, as needed.

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