

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(For optional use by AMEs or QMEs in workers' compensation cases.)

By signing this form, you are giving permission for this physician and this medical group to release your confidential medical information. It is important to fill out the entire form to make clear what information you agree to release, to whom it may be released, the purpose(s) the person receiving the information may use it for, and how long this authorization to release your medical information will remain valid. If you do not sign an authorization such as this, the Confidentiality of Medical Information Act (and other statutes) require the physician or medical group to keep your medical information confidential, unless they are required to disclose it by law.

I, authorize the following persons/entities:

(Print name and address of each person/entity)

to release the medical information listed below regarding me to the following persons, who may use that medical information only for the purpose(s) stated:

- a) Workers' Compensation benefit determination
- b) Long-term disability benefit determination
- c) Fitness for duty
- d) Medical consultation
- e) Civil litigation
- f) Other (specify) _____

_____ (name and address)

_____ (purposes designated by my initials)

The types of medical information which I give permission to release include (circle and initial appropriate types):

- A) Mental health records
- B) Drug and/or alcohol monitoring and treatment records
- C) HIV test results
- D) All other records of treatment and/or evaluation made by the persons stated above
- E) Other specified information _____

This authorization to release medical information is effective now and will remain effective until _____ (enter specific date).

Psychotherapy records will be kept until _____ (no longer than one year from date of this release) at which time they will either be destroyed or returned to the _____. (name of evaluator or treating physician)

I understand that I have a right to receive a copy of this signed authorization.

Signed this ____ day of _____, 20____, at _____ (city & state)

_____ signature of patient/examinee

_____ signature of physician