FOOT AND ANKLE CENTER OF ILLINOIS

WORKERS' COMPENSATION AUTHORIZATION FORM

Effective April 15, 2003, *HIPAA* regulations went into effect. For workers' compensation purposes, we require specific authorization from the patient in order to release information.

Patient Information:

Name: ____ DOB: ___________________________________

Social Security #: __________________________________ Date of Injury: ____________________________________

Body Part Injured: ____

Employer:

Name: ____

Address: ____

Phone #: ________________________________ Contact Person: ____

Workers' Compensation Insurance:

Carrier Name: ____

Address: ____

Claim #: ________________________________ Adjuster/Phone: ____

Personal Health Insurance:

Group Name: ____ Group #: ______________________________

ID #: ____ Phone #: ______________________________

Do you have an attorney? ________ Do you plan on retaining an attorney? ________

Attorney Name & Address: ____

Phone #: ____________________________________ Fax #: ___________________________________

I, the undersigned, hereby authorize the use and disclosure of my health information (please check all that apply):

Upcoming appointment information ☐ Faxing of medical records or reports ☐

Off-work notices ☐ Office notes ☐ Work restrictions ☐

By signing below I understand my health information will be used/disclosed to facilitate payment of my liability claim.

Patient Signature (Legal Guardian if under 18) ____

Date _____________________________________

This authorization will be valid only for the workers' compensation injury noted above. This authorization may be revoked, with written or verbal notification, except to the extent that information may be released prior to your notification to void authorization.

OFFICIAL USE ONLY

ACCOUNT #: ____________________ DR: _________________________ DATE OF SERVICE: ___________________

Revised 6/29/2011