Form 308 6.12.2020

STATE OF UTAH
LABOR COMMISSION
Division of Adjudication

AUTHORIZATION TO DISCLOSE, RELEASE AND USE PROTECTED HEALTH INFORMATION
PERMANENT TOTAL DISABILTY CLAIMS (15 YEARS OF RECORDS)
HIPAA COMPLIANT

Requesting Party:_____**Telephone: (___)**_____
Address: _____

TO:_____(Medical Providers as listed on Form 307)
_____

This authorization permits you to release a copy of records in your possession regarding any medical treatment and/or hospitalization of:

Name of Patient _____
Social Security Number_____**Date of Birth** _____
Date(s) of Injury/Occupational Disease _____

I AUTHORIZE you to disclose any information and records regarding the above named individual in your possession. This includes but is not limited to, your medical findings, diagnosis, treatment, treatment summaries, psychological or psychiatric evaluations, prognosis, clinic notes, diagnostic reports or radiology films, physical therapy records, pharmacy records, billing records or any other health information in your records for the past 15 years. I understand that based on the information released it may include information related to any substance abuse.

I UNDERSTAND that the information furnished may be used to evaluate and verify my claim for benefits for a work related injury or occupational disease. The information obtained is relevant to a workers' compensation claim(s) and may be used by persons or organizations performing a service related to, or adjudicating the claim(s).

THIS AUTHORIZATION will expire 365 days after date of signature, but may be revoked by signator in writing to the requesting party. Revocation of this authorization will not be valid if the requesting party has taken action in reliance upon such authorization. Please note that the information disclosed or used pursuant to this authorization may be subject to re-disclosure and would, therefore, no longer be protected under the terms of the HIPAA privacy rule. I also understand that the above-identified health care provider, except under limited circumstances, may not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on whether this authorization is signed.

A PHOTOCOPY OR SCANNED COPY of this authorization shall be deemed to have the same authority as the original.

I hereby certify that I have read the provisions in this authorization. I understand and agree to its terms, and authorize disclosure of the information described above.

_____ _____
Patient **Date**

STATE OF UTAH)
: ss
COUNTY OF_____)

On the_____day of_____, 20_____, personally appeared before me_____, the signer of the within instrument, who duly acknowledged to me that he/she executed the same.

_____
NOTARY PUBLIC