

**UNIVERSITY OF WISCONSIN SYSTEM  
OFFICE OF SAFETY AND LOSS PREVENTION  
WORKER'S COMPENSATION PROGRAM**

**Authorization to Use or Disclose Health Information to Worker's Compensation Self-Insurer**

Injured Employee: \_\_\_\_\_

Worker's Compensation Claim Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Authorization Expiration Date: **UNTIL WORKER'S COMPENSATION CASE IS CLOSED.**

You may refuse to sign this document. You may refuse to sign this document without jeopardizing your right to collect worker's compensation benefits. However, by assisting in the investigation of your claim, you are likely to receive benefits quicker than if you refuse to authorize the release of medical information.

1. Please list the names and addresses of health care providers/physicians/ psychologists/psychiatrists you have seen and whom are authorized to provide your records on the attached "Medical Provider List" request.
2. I authorize my entire record to be disclosed to University of Wisconsin System, or their representatives representing the State of Wisconsin
3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. The information identified above may be used by or disclosed to my Worker's Compensation self-insurer, the University of Wisconsin.
5. This information for which I'm authorizing disclosure will be used for management of my worker's compensation claim.
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the University of Wisconsin System. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my Worker's Compensation self-insurer, the University of Wisconsin System, when the law provides the System with the right to contest a claim.
7. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
8. I understand that the health care provider may not condition my treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purposes of creating protected health information for disclosure to a third party.

\_\_\_\_\_  
Signature of injured employee or legal representative

\_\_\_\_\_  
Authorization Date

\_\_\_\_\_  
(If signed by legal representative, relationship to employee)

