IOWA DIVISION *of* WORKERS' COMPENSATION

Authorization for Release of Information Regarding Claimant Seeking Workers' Compensation Benefits

Iowa Code section 85.27(2) and Iowa Administrative Code rule 876—8.9 require the release of information relating to an employee's physical or mental condition relative to a workers' compensation claim. Iowa Administrative Code rule 876—4.6 requires the claimant to serve a patient's waiver on the defendant(s) concurrently with an original notice and petition, and to update the waiver as necessary. This form may be used in claims under the jurisdiction of the Iowa Workers' Compensation Commissioner to satisfy the requirements for a claimant seeking workers' compensation benefits to release information.

To complete this form, a workers' compensation claimant or the claimant's representative must:

- Under Section I, sign and date on the labeled blanks to authorize the Iowa Division of Workers' Compensation (DWC) to release confidential information in its custody under Iowa Code section 10A.333.
- Under Section II, sign and date on the labeled blanks to authorize entities other than DWC to release information.
- Under Section III, write "Yes" or "No" next to each of three types of confidential information (substance abuse, mental health, and HIV or AIDS) and then sign and date on the labeled blanks to authorize or refuse to authorize release of such information.

For convenience, Section I of this form incorporates the *Authorization to Release Information to Third Party* form, which is used to authorize DWC to release confidential information to a third party.

Photocopy of this signed authorization shall be as effective as the original.

I. Authorization to Release Information Under the Iowa Workers' Compensation Act.

I understand that I have the right under Iowa Code section 10A.333 to keep confidential certain information filed with DWC.

I authorize DWC to disclose and deliver to _____
all confidential information of any nature in its custody, including:

A. Information from all First Reports of Injury or Illness (FROI);

B. Information from all Subsequent Reports of Injury or Illness (SROI);

C. All evidence received in contested case hearings before the agency; and

D. All transcripts from contested case hearings.

I understand that I may revoke this authorization, except to the extent that action has already been taken in reliance upon it, by giving written notice to DWC. I also understand that if I revoke, the revocation will take effect on the day it is received in writing by DWC.

X _____ _____

Signature of Claimant *or* Claimant's Legal Representative — Date

_____

Street Address — City, State, and ZIP Code

_____

If Signed by Claimant's Legal Representative, Full Name of Representative and Relationship to Claimant

II. Authorization for Release of Information and for Redisclosure.

Patient Name: _____ Date of Birth: _____

I authorize _____
to disclose and deliver to _____
any and all information **except** that relating to substance abuse (drug or alcohol), mental health, or HIV and AIDS, unless specifically authorized to be released in Section IV of this authorization.

I understand:

A. The information is being disclosed and may be used only for legal and/or litigation purposes relating to claims or suit against _____

B. This authorization may be used to obtain information from health care providers, schools, former and current employers, providers of vocational rehabilitation services, the federal Social Security Administration, and State of Iowa administrative agencies.

C. I have a right to inspect the disclosed information at any time.

D. This authorization is effective until the conclusion of a contested case on the claim.

E. I may revoke this authorization, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or recordkeeper. I also understand that if I revoke, the revocation will take effect on the day it is received in writing by the entity from whom disclosure is sought.

F. My revocation or refusal to sign this authorization will not affect my ability to obtain health care services.

G. If the person or entity that receives the information requested is not covered by federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations.

H. State of Iowa and federal law provide that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below.

I. The recipient of this authorization, **without further authorization**, may redisclose this information to the following individuals or entities, but only after they have been advised of their obligations under the law and this authorization, including the redisclosure of information:

1. Parties and their legal counsel, insurers, experts, and potential experts;

2. Agents, employees, or representatives of the parties, but only after they are involved in conducting the prosecution or defense of the case; and

3. Administrative agency and court officials hearing the claim, and their support staff.

I specifically authorize and consent to any disclosure or redisclosure described above.

_____ _____
Signature of Claimant *or* Claimant's Legal Representative Date

_____ _____
Street Address City, State, and ZIP Code

_____
If Signed by Claimant's Legal Representative, Full Name of Representative and Relationship to Claimant

III. Specific Authorization for Release of Information Protected by State or Federal Law Concerning Information Relating to Substance Abuse, Mental Health, or HIV or AIDS.

State of Iowa and federal law provide protection from disclosure of information relating to substance abuse (drug or alcohol), mental health, HIV and AIDS.

Federal law specifically requires that any disclosure or redisclosure of information relating to substance abuse (alcohol or drug), mental health, or HIV or AIDS must be accompanied by the following written statement:

> This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder.

See also Iowa Code chapters 228 and 141A, and other applicable laws.

In addition to the items identified in Section II (A) through (H), I understand:

A. The information to be released may include material that is protected by State of Iowa and federal law applicable to information relating to substance abuse, mental health, or HIV or AIDS.

B. I have a right to inspect the mental health information disclosed pursuant to this authorization at any time.

C. A copy of this authorization with respect to each request for mental health information made using it shall be provided to me or my legal representative and included in my record of mental health information.

I specifically authorize the release of:

_____ Substance abuse (drug or alcohol) information from all health care providers and facilities and any other person or entity in possession of records concerning me.

_____ Mental health information from all health care providers and facilities and any other person or entity in possession of records concerning me.

_____ HIV- or AIDS-related information, diagnosis, and test results from all health care providers and facilities and any other person or entity in possession of records concerning me.

Further, I specifically authorize disclosure and re-disclosure of this confidential information to all of the persons referred to in Section II(I) of this authorization.

x _____ _____

Signature of Claimant *or* Claimant's Legal Representative | Date

_____

Street Address | City, State, and ZIP Code

_____

If Signed by Claimant's Legal Representative, Full Name of Representative and Relationship to Claimant