Date

Claimant Name
Claimant Street Address
Claimant City, State, zip

Re: ***Claim No: _____;*** Request for the release of nonpublic personal information including personal health information.

Dear _____: *(add name of claimant here)*

_____ (the "Employer") is requesting release of your nonpublic personal information from the treating doctor to aid in the return-to-work process. This may include medical and other related information, as described in the attached authorization. The Employer is requesting your authorization to obtain this information.

Please read the attached authorization. It is valid for 24 months as written, but you may authorize the release of your nonpublic personal information for a lesser period of time on the authorization. Once you have signed this authorization, you may later revoke it at any time by writing to the Employer at _____(address), to the attention of _____(name).

Please sign and return the attached authorization to my attention at _____(address). Signing and returning the authorization will assist the Employer in the return-to-work process. Thank you in advance for your help in obtaining this information.

Sincerely,

_____ (*Name of Requestor*)

_____(*Title of Requestor*)

AUTHORIZATION FOR DISCLOSURE OF NONPUBLIC PERSONAL INFORMATION

Claimant's Name: _____

Claim No.: _____

By signing below, I, _____, (*claimant*) authorize my healthcare provider, their agents, employees or representatives, to release to _____ ("the Employer") for the return-to-work process, my medical records that include: physical therapy notes, information or medical opinions including diagnosis and prognosis, information on work status and activity restrictions, information regarding impairment and disability, and information regarding maximum medical improvement.

A copy or facsimile transmission (fax) of this Authorization is as valid as the original. This Authorization is effective on the date signed below and will remain in effect for 24 months after signing, unless otherwise specified below.

I also understand that I have the legal right to revoke this Authorization by writing to _____(the "Employer") at _____ (address), Attn: _____. If the Employer or a disclosing entity has already acted in reliance on my Authorization, my revocation will not apply to that action or transaction.

The potential exists that a recipient of nonpublic personal information might redisclose information used or disclosed pursuant to this Authorization, in which case medical and other privacy laws may no longer protect it.

With limited exceptions, treatment, payment, enrollment in a health plan, or eligibility for benefits may not be conditioned on obtaining an Authorization.

_____
Signature of Claimant or person legally authorized to act for Claimant

Please describe authority to act on behalf of Claimant_____

_____
Date Signed

___24 months_____
Time Authorization in Effect