Midwest Medical Center and Midwest Health Clinic
Workman's Compensation Authorization to Release Information

Patient Name (Printed):_____ Date of Birth:_____

*Staff please circle MMC or MHC below

I authorize Midwest Medical Center/Midwest Health Clinic One Medical Center Drive, Galena, IL 61036 to disclose the information described below to:

Name	Street Address	City	State	Zip Code	FAX #

Please specify the information to be released:

☒ **OTHER**: Billing statement and all medical records related to work injury

The requested disclosure of information is for the following purpose: X Work related injury

This authorization expires one year from date of signature. I understand that I may revoke this authorization at any time by a written request to do so.

The undersigned patient (guardian or legal representative, if applicable) hereby recognizes that the medical information and medical records sought to be disclosed are privileged and confidential, and subject to disclosure upon the authorization of the undersigned only, except where provided by law. The undersigned patient also understands that if the request is for medical records generated by the Midwest Medical Center/Midwest Health Clinic, he/she may review the disclosed information by contacting the Midwest Medical Center/ Midwest Health Clinic, One Medical Center Drive, Galena, IL 61036; Telephone (815) 777-1340 (hospital) or (815)776-7381 (clinic). I further understand that, except in the case of substance abuse, mental health or AIDS/HIV-related information, if the person or entity that receives the information is not covered by the federal privacy regulations, or is not a business associate of that person or entity, the information described above may be re-disclosed and will no longer be protected by regulation. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original. I, the undersigned patient, do hereby authorize any physician, hospital or other medical provider to furnish all records, reports, histories, diagnostic tests and evaluation, physician and nurses notes and therapy notes in their possession regarding diagnosis and prognosis for my injuries and opinions regarding the nature, extent, causation, etiology and development of my injuries for the purpose of adjudicating a Workers' Compensation claim to my employer, the State of Illinois or to the Office of the Attorney General. I hereby waive any HIPAA requirements associated with the adjudication and administration of this Workers' Compensation claim

X_____ _____
Signature of patient (or patient's legal representative) Date

Printed name of patient's legal representative:_____ _____
(Parent, Guardian, Healthcare POA, etc.) Relationship (if not the Patient)

(For internal use) Date copied:_____; (circle) mailed/faxed/personal pickup; initial_____