AUTHORIZATION TO RELEASE INFORMATION
REGARDING CLAIMANTS SEEKING WORKERS' COMPENSATION BENEFITS

Name of Patient: _____ Date of Birth: _____

Social Security No: _____

SECTION I. AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR REDISCLOSURE

I authorize _____

to disclose and deliver to: Argent, 1900 South 18th Avenue, West Bend, WI 53095

the following information related to me: Any and all information EXCEPT substance abuse (drug or alcohol), mental health, and AIDS-related information, unless specifically authorized to be released in section II of this form.

NOTE: If the information includes mental health treatment, substance abuse treatment, or HIV-related information it will not be released unless the undersigned patient agrees to the release on the reverse side of this form.

I understand the information is being disclosed and may be used only for legal and/or litigation purposes relating to claims and/or suit against _____

I understand that this Authorization may be used to obtain information from health care providers, schools, former and current employers, providers of vocational rehabilitation services, the Social Security Administration, and the Iowa Department of Workforce Development. I understand that I have a right to inspect the disclosed information at any time. This authorization is effective until the conclusion of a contested case on the claim. 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 the health care provider or record keeper. 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.

I understand that the person or entity that receives the information requested is not covered by the 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.

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 understand that the Recipient of this Authorization, WITHOUT FURTHER AUTHORIZATION, may redisclose this information to:

Parties and their legal counsel, insurers, experts, potential experts, but only after they have been advised of their obligations under the law and this authorization, including the prohibition against redisclosure of this information; Agents, employees or representatives of the parties, but only after they are involved in conducting the prosecution or defense of the case, and only after they have been advised of their obligations under the law and this authorization, including the prohibition against redisclosure of this information; Administrative agency and court officials hearing the claim, and their support staff.

I SPECIFICALLY AUTHORIZE AND CONSENT TO ANY SAID DISCLOSURE AND REDISCLOSURE DESCRIBED ABOVE.

_____ _____

Claimant or Legal Representative Date

_____

Printed Name and Relationship of Claimant's Legal Representative

SECTION II. SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT OR AIDS-RELATED INFORMATION

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and/or AIDS-related information. I SPECIFICALLY AUTHORIZE the release of confidential information relating to: [Place "YES" or "NO" in ALL applicable boxes:]

_____ 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.

Furthermore, I SPECIFICALLY AUTHORIZE disclosure and re-disclosure of this confidential information to all of the persons referred to in the REDISCLOSURE Section I.

In order for the above information to be released you must sign here AND at the end of Section I

Signature of Claimant or Legal Representative _____ Date _____

Street Address _____ City/State/ Zip Code _____

Printed Name and Relationship of Claimant's Legal Representative _____

Federal and/or State law specifically require that any disclosure or REDISCLOSURE of substance abuse, alcohol or drug, mental health, or AIDS-related information must be accompanied by the following written statement:

> This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as 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 criminally investigate or prosecute any alcohol or drug abuse patient.

See also Chapter 228 of the Iowa Code and Section 141.23(3) of the Iowa Code and other applicable laws.

14-0043 (11/04) This form may be used in connection with claims under the jurisdiction of the Iowa Workers' Compensation Commissioner.