JWF Specialty

JWF Specialty is the Third Party Administrator of Worker's Compensation for your employer,

Please complete the medical release enclosed. We need for you to **provide all physicians that you have had treatment with in the last 5 years.**

Should you have any questions, please do not hesitate to contact me at (317)706-9591: Monday – Friday 7:00 – 3:30 p.m.

Sincerely,

Christie Nygaard

Sr. Claims Specialist
christie.nygaard@jwfspecialty.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Provider _____

Address _____

_____

NAME _____ DOB:

ADDRESS _____

_____

You are hereby authorized and directed to permit, for claim resolution, worker's compensation purposes, the examination of, and the copying and reproduction in any manner, whether mechanical, photographic, or otherwise, for JWF Specialty, Co., Inc.

You are hereby authorized to release any and all medical/claim records and reports concerning medical history, physical condition, consultation, diagnosis, treatment and/or prognosis, including x-ray and other diagnostic reports, laboratory records and reports, all testing of any type and character and reports thereof, hospitalization, pharmacy records and statements of charges.

It is understood that the information in this 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.

You are hereby authorized to release any and all data listed above except the following:

It is understood that this authorization may be revoked in writing at any time. The revocation will not apply to information that has already been released in response to this authorization. This authorization is valid for sixty (60) days. I understand that authorizing the disclosure of health information is voluntary and that any disclosure of information carries the potential of re-disclosure not protected by federal confidentiality rules.

I understand that I may refuse to sign this authorization: refusal to sign this authorization will not affect my ability to obtain treatment at my own expense, enroll in any health plan or payment/benefit eligibility in any health plan, however my refusal to sign this authorization will relieve my employer and its workers' compensation carrier of any responsibility for medical expenses incurred by me for treatment that I allege is related to a work place injury. (I.C. 22-3-3-6)

A photocopy of this authorization shall have the same force and effect as the original.

X_____ _____

Signature of Patient or Legal Representative **Date**

_____

Legal Representative, Relationship to Patient

HIPPA Authorization Requirements

- **A specific description of information requested**
- **Who (facility name) is the information being requested from**
- **Who is it to be released to**
- **An expiration date, not to exceed 60 days**
- **Patient name, address, DOB & SS#**
- **Purpose for request**
- **Signature of Patient or legal Representative (description of Legal rep)**
- **A revocation statement**
- **A re-disclosure statement**
- **A conditioning of treatment statement**
- **The release must be in plain language**

_____
Family doctors Name

_____
Address

_____
City/State/Zip code

_____
Phone w/area code

_____
Hospital's Name

_____
Address

_____
City/State/Zip code

_____
phone w/area code

_____
Work Comp Doctors Name

_____
Address

_____
City/State/Zip code

_____
Phone w/area code

_____
Other Medical Facility - Therapy

_____
Address

_____
City/State/Zip code

_____
Phone w/area code

_____
Doctors Name – previous medical doctor

_____
Address

_____
City/State/Zip

_____
Phone w/area code

_____
Other Medical Facility – diagnostic test

_____
Address

_____
City/State/Zip

_____
Phone w/area code

_____
Doctors Name-previous medical doctor

_____
Address

_____
City/State/Zip

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Phone w/area code

_____
Other Medical Facility

_____
Address

_____
City/State/Zip

_____
Phone w/area code