GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Chief Risk Officer

Public Sector Workers'
Compensation Program

FORM 6 – AUTHORIZATION FOR RELEASE OF PSWCP RECORDS

HIPAA Privacy Authorization Form Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

CLAIMANT INFORMATION

Name: _____

Address (with unit number, zip code):

_____

Telephone: _____

E-mail : _____

Claim Number: _____

1. Authorization. I hereby authorize the District of Columbia's Office of Risk Management Public Sector Workers' Compensation Program to disclose my public sector workers' compensation claim file and the protected health information described below to _____ (individual or Agency seeking the information).

2. Purpose. At the request of the claimant.

3. Effective Period. This authorization for release of health information for the period of healthcare from:
   a. ☐ _____ to _____, OR

   b. ☐ all past, present, and future periods.

   If neither the above is marked, this authorization will be effective for 1 year from the date of execution.

4. Extent of Authorization

   a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse), or

   b. ☐ I authorize the release of my complete health record with the exception of the following information:
      ☐ Mental health records

□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): _____

5. This medical information may be used by the person/Agency I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until _____ (date or event), at which this time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition for obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Claimant Signature: _____

Printed Name: _____

Claim Number: _____

Date: _____

District of Columbia

Signed or attested before me on _____ (date) by _____ (name of person).

_____
Signature of Notarial Officer
Title (and Rank)
(Seal) My Commission Expires:
_____

Note: A copy of this executed form MUST be provided to the Claimant.