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# LIMITED AUTHORIZATION TO RELEASE HEALTH CARE AND WAGE LOSS INFORMATION (NO PERSONAL CONTACT ALLOWED)

**PATIENT/EMPLOYEE:** ______________________________

**DATE OF BIRTH:** ______________________________

**DATE OF INJURY:** ______________________________

**SOCIAL SECURITY NO.:** ______________________________

**Information to be released to:**

______________________ Insurance Company and/or any associates of said insurance company.

**Purpose for which disclosure is being made:**

[ ] Attorney [X] Insurance [ ] Doctor [ ] Personal

**Information to be released:**

I request and authorize the employer and health care professionals listed below to furnish to the insurance company named above wage loss information and/or protected "health care information" as that term is defined in the Washington Uniform Health Care Information Act regarding my injuries, treatment rendered, or health care received or provided **on or after** the above date of injury, or specified release date provided above if earlier than the date of injury. Medical records may include, but are not limited to: X-rays, diagnostic testing of any nature, laboratory tests, correspondence, notes, written records, or written documents of any nature.

This is **not** a release for personal contact with my employer or treating physician. It is **not** a general release of all my employment records, but only information necessary to document my wage loss following my injuries. Further, it is not a general release of all "health care information," but **only** that "health care information" (1) arising after the date of injury or after the "release date" specified herein.

**Patient Authorization:** I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. *I give my specific authorization for these records to be released.*

**As part of this authorization, all charges for reproduction of copies, plus administrative fee or charges allowed by the UHCIA will be paid by the designated insurance company. Alternatively, the carrier or defense law firm may commit in writing to make copies available at no charge to the undersigned's lawyers. Please provide a copy of such written commitment to LINGENBRINK LAW, PS. Any alteration of this release from its original typed version, or any refusal by the designated insurance company to pay for the charges associated with copies for the patient's attorneys, shall**

**render this release void.**

By signing this Limited Authorization, I do not permit the insurance company named above to release any wage loss or health care information received pursuant to this request to any other insurance company, law firm (except the above insurance company's own attorneys if subject to the same limitations contained herein), person, or entity without my express written authorization.

**My Rights:** I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I may revoke this authorization in writing. However, I understand that any action has been taken in reliance thereof cannot be reversed and my revocation will not affect those actions; and unless earlier revoked, this authorization shall expire within 90 days from the date of this release.

**Information to be released from:**
**(Records may be obtained ONLY from the following employer(s) and/or health care professionals)**

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

______________________________
Signature

Date ______________________

______________________________
Relationship or status if
signed by anyone other than the
employee or patient.