Authorization for Release of Medical Records

By the Hospital/Provider for the purpose of administering a Mashantucket Pequot Tribal Nation Workers' Compensation Claim for Benefits

Mashantucket Pequot Tribal Nation
Workers' Compensation Commission
P.O. Box 3060
Mashantucket, CT 06338-3060
Phone (860)396-2424 Fax (860)396-2060
MPTNWCC@mptn-nsn.gov

(W.C.C. use only)

Patient Name: _____ D.O.B.: _____
Month Day Year

Body Part(s): _____

Claim #: _____

I, the undersigned, authorize: _____
(Hospital/Provider)

to disclose, orally or in writing, protected health information {PHI} to:

_____
(PERSON OR ENTITY TO WHOM INFORMATION IS TO BE DISCLOSED)

and its attorneys/representatives. The PHI to be disclosed is relevant medical records and reports relating to my medical treatment/consultation/examination and/or diagnostic procedures performed at the above-named medical facility and which pertain to an injury/occupational disease for which I am claiming benefits under the Mashantucket Pequot Tribal Nation Workers' Compensation Act. I understand the information disclosed based on this authorization may include mental health treatment records and information regarding HIV/AIDS status, treatment or testing. **INFORMATION RELATING TO TREATMENT FOR ALCOHOL OR DRUG ABUSE WILL NOT BE RELEASED WITHOUT MY SPECIFIC CONSENT IN ACCORDANCE WITH FEDERAL, STATE AND TRIBAL LAW.*** I understand I have the right to inspect or copy the PHI to be disclosed as permitted under federal HIPAA law, state and tribal law.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION; HOWEVER REFUSAL TO AUTHORIZE RELEASE OF RELEVANT INFORMATION MAY RESULT IN DELAY OR SUSPENSION OF MY WORKERS' COMPENSATION BENEFITS.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION.
In order to revoke this authorization I may at the time, send written notification to the above-named HOSPITAL/PROVIDER. I understand that my revocation of this authorization is ineffective to the extent that the above-named HOSPITAL/PROVIDER has relied on this authorization to disclose PHI relating to me.

I UNDERSTAND THAT PHI DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE PERSON OR ENTITY I HAVE IDENTIFIED ABOVE AND MAY NO LONGER BE PROTECTED FROM DISCLOSURE TO OTHERS BY FEDERAL, STATE OR TRIBAL LAW.
I understand that the above-named HOSPITAL/PROVIDER may not condition my treatment on whether I provide authorization for the requested use or disclosure.

I UNDERSTAND THAT I HAVE THE RIGHT TO DETERMINE A DATE OR EVENT AT WHICH TIME THIS AUTHORIZATION EXPIRES.
I am identifying the expiration date of this authorization to be COMPLETION OF WORKERS' COMPENSATION LITIGATION AS EVIDENCE BY A STIPULATION OR FINDING AND AWARD/DISMISSAL, OR IN THE EVENT OF APPELLATE REVIEW, A FINAL DETERMINATION MADE BY THE HIGHEST APPELLATE AUTHORITY TO WHOM AN APPEAL IS MADE.

I further understand that federal HIPAA law does not require me to provide an authorization in this form as the purpose of this authorization relates to Workers' Compensation matter. However, I understand that as a practical matter, my authorization in this form may facilitate the processing and administration of my claim for Workers' Compensation benefits.

My signature below indicates that I have read and understand this Authorization and its terms.

_____ _____
Signature of Patient *Date* Month Day Year

** Any consent to release information pertaining to treatment for alcohol or drug abuse must conform to the requirements of federal, state and tribal law and regulation.*

Revised 11/5/14