**UAB ON-THE-JOB INJURY/ILLNESS PROGRAM**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. The purpose of the disclosure is to allow representatives of the University of Alabama at Birmingham (UAB) to review my request for benefits under the UAB On-The-Job Injury/Illness Program.

Patient's Name: _____

Social Security Number: _____

Organizations providing information:

The Workplace (UAB Occupational Medicine)
University of Alabama at Birmingham and related facilities (University Hospital)
University of Alabama Health Services Foundation and related facilities (The Kirklin Clinic, Selma Family Medicine and others)
Other _____

Organizations receiving information:

Brentwood Services Administrators (the contract administration of On-The-Job Injury claims for UAB) and UAB Department of Human Resource Management
UAB Department Management

Specific description of information:

Any and all information requested by the above referenced organizations related to my on-the-job injury that occurred on _____.

Neither this disclosure nor any subsequent re-disclosure may be protected by the Health Insurance Portability and Accountability Act (HIPAA).

I understand that signing this record release is voluntary. However, failure to do so may result in a denial of the On-The-Job Injury/Illness Program benefits because the program administrator must review medical information (including physicians notes, authorization to return to work, medications ordered, etc.) in order to determine eligibility for benefits.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any affect on any actions taken before notification or revocation was received by the providing organization.

This form is valid until the expiration of all events related to the processing of claims relating to OJI benefits, including but not limited to participation in litigation or administrative hearings.

Signature of patient: _____

Date of authorization: _____