

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use and disclosure of my personal health information upon request by WorkPartners from all claims processors, providers and insurers contracted by my employer including, but not limited to, those who administer my employer's Group Health, Short-Term Disability, Long-Term Disability, Workers' Compensation and Employee Assistance Program (EAP).

I authorize the above persons or organizations, any medical practitioner, hospital, clinic, other medical or medically related facility, pharmacy, insurer, claims administrator, and my employer(s) to disclose or furnish to WorkPartners, my employer, or any of their authorized representatives, all facts concerning my medical condition and/or disability (including physical, mental health, alcohol, substance abuse and HIV related information), wages or earnings, and to allow inspection of and provide copies of any medical records (including diagnosis, prognosis, prescriptions or medication, psychiatric, drug or alcohol abuse treatment). I further authorize WorkPartners to disclose the facts associated with my disability including, but not limited to, medical and mental health claims and diagnosis, to my employer and health benefits provider(s) (claims processors, disease or health management companies and insurers) to determine eligibility for health or disease management programs, for administration and operations of health benefit plans, coordination of care and quality assurance, improvement and utilization review programs.

I understand that this information may be used to determine my eligibility for benefits or compensation to which I may be entitled under any benefit plan or practice of my employer, which requires evaluation for physical or mental condition including, but not limited to, a leave from work for medical reasons. I also understand that my healthcare provider will not condition my treatment based on this authorization. I understand this authorization is valid for the duration of my claim for disability benefits and up to the maximum period allowed by law.

IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I may revoke this authorization at any time before its expiration date by notifying WorkPartners in writing, but the revocation will not have any affect on any actions the party took before it received the revocation. I understand that my personal health information may be released to others in accordance with the terms of this release and I have a right to receive a copy of this authorization. Re-disclosure of my health information by WorkPartners or any other party is not protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

First Name:		Last Name:	
Street Address:			
City, State and Zip:		Telephone:	
UPMC Location:	Last Day Worked:	First Day Away From Work:	

I certify that all of the information is, to the best of my knowledge, true, correct and complete. Please fill in the above information, sign and return this form by fax to 412-473-7437 OR by mail to WorkPartners, PO Box 2973 Pittsburgh, PA 15230

 Employee's Signature

 Date Signed

 Name of Personal Representative who has
 Authority to Sign on Behalf of the Employee

 Signature of Personal Representative who has
 Authority to Sign on Behalf of the Employee