GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES

DEPARTMENT OF LABOR

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Workers' Compensation Administration

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

CLAIMANT INSTRUCTIONS: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) set standards for guaranteeing the privacy of individually identifiable health information and the confidentiality of patient medical records. By completing and signing this form, you authorize your healthcare provider to file medical reports with the parties that you choose (such as the Workers' Compensation Administration), you have the right to refuse to sign this Authorization. If you sign, you have the right to revoke this Authorization at any time by mailing a request to revoke to the health care provider. You have the right to receive a copy of this Authorization.

IMPORTANT: Failure to execute this authorization will interfere with your ability to obtain workers' compensation benefits.

I, _____Name_____, Social Security Number: _____ of _____ United States Virgin Islands hereby authorize _____Provider_____ to disclose all medical records or other information regarding my treatment, hospitalization, and/or outpatient care. The information disclosed will be used in connection with my _____Date of Injury_____ claim for benefits to the _____Body Part_____under the Virgin Islands Workers' Compensation Statue.

Date of Birth: _____

Mailing Address: _____

_____ _____

Injured Worker's Name (Signature) **Date**

REDISCLOSURE: I understand that once the above-referenced health care provider discloses health information based on this Authorization, that health information is no longer protected by HIPAA and the Privacy Rule.

EXPIRATION DATE: This Authorization expires upon the final closing of the workers' compensation claim(s) for which it is executed.

I have had the opportunity to review and understand the content of this Authorization. By signing this Authorization, I confirm that it accurately reflects my wishes. (Version June 2019)

Form #: _____