MeM

Authorization To Obtain Information

I AUTHORIZE any licensed physician, medical practitioner, nurse, pharmacist, hospital, clinic or other medical or medically related facility, insurance or reinsurance company, consumer reporting agency, employer or former employer who has any information as to the diagnosis, treatment or prognosis of any physical or mental condition of me, and any information regarding my occupation and salary, to give any and all such information to Missouri Employers Mutual Insurance, its employees, reinsurers, any designated Managed Care Organization, and the Division of Workers' Compensation to which I am submitting a claim.

I UNDERSTAND that the information obtained by use of this authorization will be used by the company to determine eligibility for workers compensation benefits. Any information obtained will not be released to any person or organization except to other persons or organizations performing a business or legal service in connection with my claim or as may be otherwise permitted or required by law. The release of my Protected Health Information to a person or organization not subject to federal law governing privacy, which then rediscloses my Protected Health Information, may mean that the protections afforded by the federal privacy laws no longer apply.

I UNDERSTAND the information contained in these records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and drug or alcohol use or abuse. **I HEREBY CONSENT AND AUTHORIZE** the medical record provider to release and provide records containing this information to Missouri Employers Mutual Insurance.

I AUTHORIZE MEM to discuss my health information with my authorized treating physician, evaluating physician and/or medical care provider and with my Employer and their representatives and agents for the purpose of managing and adjudicating my workers compensation case(s).

I KNOW that I may request to receive a copy of this authorization.

I AGREE that a photocopy of this authorization shall be as valid as the original.

I AGREE that this authorization shall be valid for the duration of this claim, unless I choose to withdraw this authorization in writing.

_____ _____

Date **Print Name of Injured Employee**

_____

Signature of Injured Employee or Authorized Representative

*** NOTE TO RECORD PROVIDER:**

The Health Insurance Portability and Accountability Act (HIPAA) expressly indicates that a patient's consent or authorization is not required for records to be disclosed when the request is made pursuant to workers compensation laws. See 45 CFR Section 164.512(1). This request for records is made pursuant to The Missouri Workers' Compensation Act, Section 287.210 RSMo., subsections 5 and 6.

Submit completed form to:

Kim Davis, Coordinator of Benefits & Wellness
Smithville R-II School District
655 South Commercial Avenue
Smithville, MO 64089
Fax: 816-532-4192
Email: davisk@smithville.k12.mo.us