Request for Release of Medical Records for Oregon Workers' Compensation Claim

To: Custodian of medical records

Name: _____

Address: _____

_____

Worker information

Name: _____

Insurer claim number: _____

Date of injury: _____

Worker authorization/signature

By my signature, I authorize medical providers and other custodians of the claim record to release medical records **relevant** to my workers' compensation claimed conditions (see below) to the requester named below, as provided in ORS 656.252, OAR 436-010-0240 and OAR 436-060-0017. **Medical information relevant to the claim includes a past history of complaints or treatments of a condition similar to that presented in the claim or other conditions related to the same body part.**

Worker's signature: _____ *Date*: _____

Claimed conditions (Requester: List below; be specific.)

Separate authorization is required for release of the following information

- The worker's participation in federally funded drug and alcohol abuse treatment programs under Federal Regulation 42, CFR 2.
- HIV-related information protected by ORS 433.045(3).

OAR 436-010-0240 requires that medical providers respond to a request for medical records within 14 days of the date of the request. Failure to respond within 14 days to a request sent by certified mail may subject the medical provider to penalties under OAR 436-010-0340 or 436-015-0120. This request is being sent on _____.

Please send relevant medical records by _____ to:

Requester's name: _____

Attention: _____

Address: _____ Phone no.: _____

_____ Fax no.: _____

Note: People who release medical information in accordance with Oregon Administrative Rules shall bear no legal liability for such disclosure.