Oriska Insurance Company

Limited Release of Health Information Acknowledgement (HIPAA)

To Claimant: If you received treatment for a previous injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's accident and health insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. To Health Care Providers: A copy of this HIPAA-compliant release allows you to disclose health information. Health care providers who release records must follow New York State law and HIPAA. If you need assistance in filling out this form, please contact Claims@Oriska.com or call (866)808-3933.

This release is:

- **Voluntary**. Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited**. It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary**. It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable**. You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's accident and health insurer. Note: You may not cancel this release with respect to medical records already provided.
- **For records only**. It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's accident and health insurer.
- This form does NOT allow your health care provider(s)to release the following types of information:
    - HIV-related information
    - Psychotherapy notes
    - Alcohol/Drug treatment
    - Mental Health treatment (unless you check below)
    - Verbal information (your health care providers may not discuss your health care information with anyone)
    - Any medical records released will become part of your accident and health file and are confidential under HIPAA.

Your Information (Claimant)

Name: _____

Mailing Address: _____

Social Security Number: _____

Date of Birth: _____ Date of Injury/Illness: _____

Current Injury/Illness, Including All Body Parts Injured: _____

_____

☐ Check here if you allow your health care provider(s) to release mental health care information

Your Health Care Provider(s) (List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

Provider: _____

Phone Number: _____

Mailing Address: _____

Other Provider (if any): _____

Phone Number: _____

Mailing Address: _____

Read and Sign Below

I hereby request that the health care provider(s) listed above give my accident and health insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

_____

Claimant's Signature Date

If the claimant is unable to sign, the person signing on the claimant's behalf must fill out and sign below.

_____

Your Name Relationship to Claimant Signature Date