

LIMITED CERTIFICATE AUTHORIZING WRITTEN RELEASE OF MEDICAL / HEALTHCARE INFORMATION



EMPLOYEE: _____ ADDRESS: _____

DATE OF INJURY: _____ SOCIAL SECURITY NUMBER: _____

BRIEF DESCRIPTION OF BODY PART(S) INJURED: _____

EMPLOYER: _____ ADDRESS: _____

INSURER: _____ ADDRESS: _____

ATTORNEY: _____ ADDRESS: _____

I hereby authorize the above employer, insurer, or their attorney to obtain from any hospital, physician, osteopath, chiropractor, or other health care provider, after payment to the provider of a reasonable fee, any written information only which is or has been prepared in connection with my examination or treatment regardless of date which relates to my _____ (i.e. body part and/or condition) only. This certificate of authorization remains valid and must be honored for as long as I continue to make any claim for compensation, any compensation payment scheme remains in effect, or I receive compensation. This certificate of authorization does NOT permit the release of any information regarding psychological, substance abuse, sexually transmitted disease treatment, testing, or counseling and does NOT authorize oral communication with or by any health care provider.

EMPLOYEE SIGNATURE

DATE

NOTICE TO THE EMPLOYEE

YOU HAVE 20 DAYS FROM RECEIPT OF THIS CERTIFICATE TO SIGN AND RETURN IT TO THE EMPLOYER OF INSURER. FAILURE TO SIGN AND RETURN THIS CERTIFICATE MAY RESULT IN A SUSPENSION OF ACTIVITY ON YOUR CLAIM FOR COMPENSATION, OR IF YOU ARE CURRENTLY RECEIVING COMPENSATION, YOUR PAYMENTS OF COMPENSATION MAY BE SUSPENDED UNTIL YOU SIGN AND RETURN THIS CERTIFICATE.

THIS IS THE AUTHORIZED FORM FOR THE RELEASE OF MEDICAL AND RELATED INFORMATION UNDER THE MAINE WORKERS' COMPENSATION ACT AND IS INTENDED TO SUPPLEMENT THE RIGHTS TO SECURE MEDICAL INFORMATION SET FORTH BY TITLE 39-A OF THE MAINE REVISED STATUTES ANNOTATED AND CHAPTER 12 SECTION 18 OF THE BOARD'S RULES AND REGULATIONS.