RISK ADMINISTRATION SERVICES, INC.

Injured Worker:

Claim No.:

Date of Birth:

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my medical information (also known as protected health information) as described below.

Facility Name: _____

Enter the name of doctor's office, hospital, or other healthcare facility you are authorizing to send us your medical information.
Use separate form for each if more than one.

I, _____, authorize all persons or entities that provided medical treatment to me to disclose the following medical information in your possession to RAS, its employees, agents, subcontractors and authorized representatives.

Please provide RAS with any and all information in your possession concerning my physical condition, past, present and future, including but not limited to, healthcare history, diagnosis, condition, treatment or evaluation and other medical information so that they may use it or disclose it to evaluate, administer and resolve my claim related to injuries I received on _____. I understand that the medical information that is disclosed may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. *

I, _____, authorize the State to release to Insurer/RAS and/or its representatives a complete copy of all records pertaining to past or present Workers' Compensation claims.

I hereby authorize Insurer/RAS to reproduce, distribute or use any or all protected health information from any past or present Workers' Compensation claims that I may have had with Insurer/RAS. I further authorize Insurer/RAS to retain any or all protected health information it may receive related to the injury I received on _____.

This authorization shall be in force and effective until my claim related to the injury, I received on _____ is resolved, at which time this authorization to use or disclose this protected health information expires. I understand that I may revoke this authorization by notifying [**RAS Inc, PO Box 89310, Sioux Falls, SD 57109**] in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by RAS or the Releasing Party in Reliance on it before I revoked it.

As the person signing this Authorization for Release of Protected Health Information, I understand that I am giving permission to RAS to obtain and use protected health information. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

A copy of this authorization may be accepted with the same authority as the original.

I understand this authorization is voluntary. As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the **health care entity** may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. While I do not need to sign this authorization to ensure **healthcare treatment**, I understand that failure to do so may have impact on my entitlement to payment of Workers' Compensation benefits.

Print Name of Patient or Personal Representative	Description of Personal Representative's Authority
X **Signature of Patient or Personal Representative**	Date

*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

CORPORATE OFFICE IN SIOUX FALLS, SD
OFFICES IN EAGAN, MN · OMAHA, NE · LAS VEGAS, NV

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