

**UNION CONSTRUCTION WORKERS' COMPENSATION PROGRAM**

*Administered by Wilson-McShane Corporation*

**AUTHORIZATION FOR RELEASE OF INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Other Name Used: \_\_\_\_\_ DOI: \_\_\_\_\_  
 Phone Number: (    ) \_\_\_\_\_ SSN: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ Employer: \_\_\_\_\_  
 \_\_\_\_\_ Local Union \_\_\_\_\_  
 \_\_\_\_\_ Name & #: \_\_\_\_\_

<b>Information Released from:</b>	<b>Info Released to:</b>
<i>Provider/Facility</i>	Union Construction Workers' Compensation Program
<i>Address</i>	Attn: Elliot Herland/Kevin Gregerson
<i>Address</i>	3001 Metro Drive, Suite 500
	Bloomington MN 55425
<i>Date Needed:</i>	Fax: (952) 851-3566

**Medical Record Release:**

Records concerning: \_\_\_\_\_

Dates of Treatment: **All** \_\_\_\_\_

- |   |  |
|---|--|
| <input type="checkbox"/> Mental Health Visit/Psychological Reports                          | <input checked="" type="checkbox"/> History and Physical Exam        |
| <input checked="" type="checkbox"/> Consultation/Follow up Reports                          | <input checked="" type="checkbox"/> Clinical Visit & Reports Summary |
| <input checked="" type="checkbox"/> X-Ray/EMG/EKG/Lab Reports                               | <input checked="" type="checkbox"/> Operative Reports                |
| <input type="checkbox"/> Drug/Alcohol Abuse Treatment Records                               | <input type="checkbox"/> Other (specify) _____                       |
| <input checked="" type="checkbox"/> Health & Welfare Fund Eligibility Status/Claims History |  |

All Records pertaining to AIDS or HIV testing will be released unless indicated here:

**DO NOT RELEASE RECORDS RELATED TO AIDS OR HIV TESTING**

**This information is necessary for the purposes of evaluation of liability and/or to make prompt payment of benefits found to be owing on the above captioned Workers' Compensation claim in accordance with the Minnesota Workers' Compensation Statute.**

This authorization specifically includes records prepared prior to the date of this authorization and records prepared after the date of this authorization during the pendency of this proceeding (including claims and potential claims).

This consent will automatically expire one year from the date of the authorization in accordance with Minnesota Statute 15.163. I may, however, revoke the authorization in writing at any time.

This is a full and sufficient authorization, pursuant to Minnesota Statute §144.335. I understand that the Union Construction Workers' Compensation Program and Wilson-McShane Corporation are not health care providers or health plans and the once released to them, my protected health care information may no longer be protected by federal privacy regulations and can no longer be protected by my health care provider, even though the information will be protected from redisclosure to third parties.

**A photocopy of this release is valid as the original.**

\_\_\_\_\_  
Signed (patient/guardian/next of kin)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Reason patient unable to sign