

**AUTHORIZATION TO RELEASE INFORMATION  
REGARDING CLAIMANTS SEEKING WORKERS' COMPENSATION BENEFITS**

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security No: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**SECTION I. AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR REDISCLOSURE**

I authorize \_\_\_\_\_  
to disclose and deliver to: Argent, N16 W23217 Stone Ridge Drive, Suite 200, Waukesha, WI 53188  
the following information related to me: Any and all information EXCEPT substance abuse (drug or alcohol), mental health, and AIDS-related information, unless specifically authorized to be released in section II of this form.

**NOTE:** If the information includes mental health treatment, substance abuse treatment, or HIV-related information it will not be released unless the undersigned patient agrees to the release on the reverse side of this form.

I understand the information is being disclosed and may be used only for legal and/or litigation purposes relating to claims and/or suit against \_\_\_\_\_

I understand that this Authorization may be used to obtain information from health care providers, schools, former and current employers, providers of vocational rehabilitation services, the Social Security Administration, and the Iowa Department of Workforce Development. I understand that I have a right to inspect the disclosed information at any time. This authorization is effective until the conclusion of a contested case on the claim. I understand that I may revoke this Authorization, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or record keeper. I also understand that if I revoke, the revocation will take effect on the day it is received in writing by the entity from whom disclosure is sought.

I understand that the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations.

Iowa and Federal law provide that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below. I understand that the Recipient of this Authorization, WITHOUT FURTHER AUTHORIZATION, may redisclose this information to:

Parties and their legal counsel, insurers, experts, potential experts, but only after they have been advised of their obligations under the law and this authorization, including the prohibition against redisclosure of this information; Agents, employees or representatives of the parties, but only after they are involved in conducting the prosecution or defense of the case, and only after they have been advised of their obligations under the law and this authorization, including the prohibition against redisclosure of this information; Administrative agency and court officials hearing the claim, and their support staff.

**I SPECIFICALLY AUTHORIZE AND CONSENT TO ANY SAID DISCLOSURE AND REDISCLOSURE DESCRIBED ABOVE.**

\_\_\_\_\_  
Claimant or Legal Representative \_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Relationship of Claimant's Legal Representative

