WORKERS COMPENSATION AUTHORIZATION

Thomas Chittenden Health Center will submit a claim on your behalf to your worker's compensation only if all of the required information below is complete. Please note that in the event your worker's compensation insurance declines the payment or has not responded to us within 45 days, you will be responsible for all related charges. In such a case, you may ask us to bill your health insurance.

REQUIRED INFORMATION

PATIENT NAME _____

DOB _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PRIMARY PHONE # _____ SECONDARY PHONE # _____

Date of injury _____

Description of injury_____

Employer _____
Employer Address _____
Worker's Compensation Insurance Name _____
Address _____
City _____ State _____ Zip Code _____

Claim Number _____

Note: The release of medical records relative to worker's compensation claim filed pursuant to Title 21 of the Vermont Statutes is not governed by the terms and provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR 164.512 (1).

By signing below, you are authorizing Thomas Chittenden Health Center to release your worker's compensation insurance company, adjustor, or employer ALL medical records you may have relating to the treatment or diagnosis of your injury. This includes history, findings, x-rays, bills, statements, diagnosis, lab reports and all other medical or hospital records in our possession including, but not limited to, records of treatment rendered by us as well as any medical records in our possession upon which we relied in any way in our treatment and/or diagnosis of your condition.

SIGNATURE: _____ DATE: _____

Thomas Chittenden Health Center, 586 Oak Hill Rd, Williston, VT 05495
Phone (802) 878-8131 Fax (802) 879-6853