VERMONT ORTHOPAEDIC CLINIC

3 ALBERT CREE DRIVE, RUTLAND, VT 05701
PHONE: 802-776-2205 FAX: 802-773-0934

WORKER'S COMPENSATION AUTHORIZATION

Vermont Orthopaedic Clinic will submit a claim on your behalf to your Worker's Compensation insurance only if all the required information below is completed. 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 case, you may request us to bill your health insurance.

PATIENT NAME: _____ DOB: _____ SSN: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

EMPLOYER CONTACT NAME: _____

EMPLOYER PHONE: _____

DATE OF INURY: _____ TYPE OF INJURY: _____

WORKER'S COMPENSATION CARRIER NAME AND ADDRESS: _____

_____

_____

_____

CLAIM #: _____

CARRIER PHONE: _____

CASE MANAGER: _____

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 Vermont Orthopaedic Clinic to release to your worker's compensation insurance company, Adjuster, or employer ALL medical records you may have relating to 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 other medical records in our possession upon which we relied in any way in our treatment and/or diagnosis of your condition.

Signature _____ Date _____