AUTHORIZATION TO RELEASE OF PROTECTED HEALTH INFORMATION

I, First Name, Last Name, hereby authorize WorkCare, Inc. and any of its agents and employees, and any of its subsidiaries and their agents and employees ("WorkCare") to release protected health information about me, as specified below, from records maintained by WorkCare.

I understand that information disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I am signing this authorization voluntarily and understand that my health care treatment will not be affected if I do not sign this authorization.

1. About Me

First Name First Name Middle Initial (optional) Middle Initial Last Name Last Name

Date of Birth _____ ☐ I am under age 18 at the time of this request

Street Address Street Address City City

State State Zip Code Zip Code Phone Phone Number Email Email Address

My Employer (WorkCare Client) My Employer

2. Information to be Released

◯ All health care records ◯ Other

If "Other" is chosen please describe, with specificity, the information you authorize to be released:

WorkCare does not maintain records related to HIV testing, genetic testing, mental health treatment, or substance use disorder treatment. If any such information is contained in correspondence we've received or forwarded, I authorize its release by checking below. Please check box(es) below **only** if you want the following information released:

☐ I understand and authorize release of any such information if present:

- ☐ HIV Test Results
- ☐ Genetic Testing Records
- ☐ Substance Use Disorder Results
- ☐ Psychotherapy Records

3. Reason for Sharing This Information

Please select one option or records will not be released.

◯ At my request ◯ Other If "Other" is chosen, an explanation must be provided:

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4. Information to be Released to:

Name/Organization (mandatory) Name/Organization Phone Phone Number

How to release (Check the appropriate box):

☐ Mail: Street Address Street Address City City

State State Zip Code Zip Code

☐ Email*: Email Address Email Address

* I understand that email is not a secure form of communication and thus WorkCare cannot guarantee confidentiality of email communications. There is a risk that my health information could be intercepted, accessed, read, or altered during email transmission. I request my information to be sent via email, which may be unencrypted, despite the risks.

5. How Long This Permission Lasts

This permission to share my information is good until MM/DD/YYYY If I do not list a date, this permission will last for one year from the date it is signed.

I understand that no additional authorization is required for the release of medical information obtained after the date of this authorization so long as the medical information is released in accordance with the terms of this authorization and my authorization has not expired or been revoked by me.

I understand that I can change my mind and revoke this permission at any time.
To do this, I need to send a letter to: WorkCare, Inc.
Attn: Legal Department
1100 W. Town and Country Road, Suite 1300
Orange, CA 92868

Or send email to: contracts.team@workcare.com

If the information has already been released before my revocation is received, I understand that it is too late for me to change my mind and revoke my permission.

6. Signature

Signature _____ Date _____

Printed name Printed Name

If this form is being filled out by someone who has the legal authority to act for you (such as a legal parent or guardian if you are under 18, or a court-appointed executor or health care agent), please provide the following:

Printed Name of person completing this form Printed Name of Authorized Person

Signature of person completing this form _____

Describe how this person has legal authority to request on your behalf:

_____

Attach legal documentation to verify that this person has legal authority to request on your behalf.

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Special Considerations for Mental Health, Sexual Health Records, and Substance Abuse Disorders

1. Stricter State Laws May Apply
   - Many states treat certain records as more sensitive and require separate or additional authorization.
   - This often includes:
     - Psychotherapy notes
     - Substance use disorder treatment records (see #3 below)
     - Reproductive or sexual health services (especially for minors)

2. Psychotherapy Notes (Special Case under HIPAA)
   - HIPAA gives extra protection to psychotherapy notes (notes kept separate from the medical record and used solely by the therapist).
   - These require a separate, specific authorization:
     - You cannot combine authorization for psychotherapy notes with general medical records.
     - Must clearly state the release of "psychotherapy notes."

3. Substance Use Disorder Records (42 CFR Part 2)
   - If the provider is part of a federally assisted substance use treatment program, then 42 CFR Part 2 applies, and:
     - More stringent rules than HIPAA govern disclosure.
     - The release form must include:
       - Explicit consent for substance use records
       - Purpose of the disclosure
       - Statement that redisclosure is prohibited without additional consent

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