



## AUTHORIZATION TO RELEASE OF PROTECTED HEALTH INFORMATION

I, \_\_\_\_\_, 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 \_\_\_\_\_ Middle Initial (optional) \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_  I am under age 18 at the time of this request

Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

My Employer (WorkCare Client) \_\_\_\_\_

### 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:

**4. Information to be Released to:**

Name/Organization (mandatory) \_\_\_\_\_ Phone \_\_\_\_\_

How to release (Check the appropriate box):

 Mail: Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

 Email\*: 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 \_\_\_\_\_ 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

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 \_\_\_\_\_

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 \_\_\_\_\_

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.

**7. Submission Instructions (Where to send this form):**

Please submit the completed and signed form using one of the following methods:

Email: [medical.records@workcare.com](mailto:medical.records@workcare.com)

Mail: WorkCare, Inc.  
Attn: Medical Records  
1100 W. Town and Country Road, Suite 1300  
Orange, CA 92868

**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