

# Request for Release of Medical Records for Oregon Workers' Compensation Claim

**To: Custodian of medical records** \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_**Worker information** \_\_\_\_\_

Name: \_\_\_\_\_

Insurer claim number: \_\_\_\_\_

Date of injury: \_\_\_\_\_

**Worker authorization/signature** \_\_\_\_\_

By my signature, I authorize medical providers and other custodians of the claim record to release medical records **relevant** to my workers' compensation claimed condition(s) (see below) to the requester named below, as provided in ORS 656.252, OAR 436-010-0240 and OAR 436-060-0017. **Medical information relevant to the claim includes a past history of the complaints of, or treatment of, a condition similar to that presented in the claim or other conditions related to the same body part.**

Worker's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Claimed conditions** (Requester: List below; be specific.) \_\_\_\_\_**This form does not authorize release of the following information** \_\_\_\_\_

- The worker's participation in federally funded drug and alcohol abuse treatment programs under Federal Regulation 42, CFR (2).
- HIV-related information **unless** the claimed condition is HIV or AIDS or when such information is directly relevant to the claimed condition(s).

**OAR 436-010-0240 requires that medical providers respond to a request for medical records within 14 days of the date of the request. Failure to respond within 14 days to a request sent by certified mail may subject the medical provider to penalties under OAR 436-010-0340 or 436-015-0120. This request is being sent on \_\_\_\_\_.**

Please send relevant medical records by \_\_\_\_\_ to:

Requester's name: Empire Pacific Risk Management, Inc.

Attention: \_\_\_\_\_

Address: **5300 SW Meadows Road, Suite 220  
Lake Oswego, OR 97035**Phone: **503-968-6300**