LITTLE TRAVERSE
PRIMARY CARE

Worker's Compensation/DOT Protected Information Release

I, _____ _____,
(Patient Name) **(Date of Birth)**
hereby release and authorize my treating doctor/nurse practitioner/provider at **Little Traverse Primary Care/Physician Support Services**, to give my Employer:

_____,
(Employer Name)
pertinent information about my current work-related injury or DOT (Department of Transportation) services for _____ and how that injury may affect my
(Date of Injury or DOT physical)
ability to complete the functions of my job. This authorization includes all related follow-up visits and treatment for this injury/physical.

(MUST INITIAL) I understand that my health information being requested may include information regarding: (Please initial the following):

_____ Communicable disease and infection information as defined by statue and Michigan Department of Public Health Rules which include venereal disease "VD", tuberculosis "TB", hepatitis B, human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDA", and AIDS related complex "ARC".

_____ Alcohol and/or drug abuse treatment information protected under regulation in 42 Code of Federal Regulations, Part 2.

_____ Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.

To address privacy concerns, HIPAA Privacy Rule 45 CFR 512(1) specifically authorizes provider disclosure of protected health information without an individual's authorization to the extent necessary to comply with workers' compensation laws. A copy of this form shall have the same effect as the original.

_____ **Date:**_____
Employee/Patient signature

_____ **Phone#**_____
Street Address

_____
City, State, Zip Code