MEDICAL AUTHORIZATION

RE: Name: Date:
SS#: Claim #:
DOB:

YOU ARE HEREBY AUTHORIZED TO RELEASE TO

Illinois Public Risk Fund
CLAIMS ADMINISTRATION

1411 Opus Place, Suite 200
Downers Grove, IL 60515-1191
Telephone: (888) 532-6981, Fax (888) 223-1638

Or any representative acting on it's behalf, including my employer, and to permit them to examine and/or copy:

Any and all hospital records, medical records, psychological records, x-ray films and their reports, all tests of any type and character and their reports, statements of charges and any and all records of medical care, history, condition, treatment, diagnosis, prognosis, etiology or expense in your possession or control pertaining to the undersigned. (Illinois Mental Health and Developmental Disabilities Confidentiality Act –REF. 740 ILCS 110/1 et seq; and Illinois Workers' Compensation Act 820 ILCS 305/8(a))

You are also authorized to discuss with them my injuries, physical condition, treatment and care and to furnish them with a written report regarding same.

The purpose for releasing this information is:

(A) To facilitate the evaluation of my claim for Workers' Compensation benefits. (REF: 50 IL Admin Code, CH II § 7110.70).

(B) To Permit said disclosed information to be admitted into evidence at a hearing on my claim for said benefits pursuant to the appropriate rules of practice before the Illinois Industrial Commission.

A photostatic copy of this authorization shall be as valid as the original. This authorization is valid for the duration of the claim.

You are hereby released from any and all liability or responsibility, which could or might result because of the disclosure of any information pursuant to this authorization.

_____ _____
DATE SIGNATURE

_____
PRINT NAME

Note: This Authorization for Disclosure is intended to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and the Act's "Privacy Rule" relating to the authorized Disclosure of Protected Health Information (PHI) to employers, administrators, insurers, and other persons involved in state workers' compensation systems in accordance with 45 C.F.R. 164.512.

SUPERVISOR'S INVESTIGATION REPORT

1. City:	2. Department:
3. Exact Location:	4. Date of Occurrence:
5. Time of Occurrence:	6. Date Reported:
INJURY OR ILLNESS	**PROPERTY DAMAGE**
7. Injured's Name:	13. Property Damaged:
8. Occupation:	14. Estimated Costs:
9. Part of Body Affected:	15. Actual Costs:
10. Nature of Injury/Illness:	16. Nature of Damage:
11. Object/Equipment/Substance/Inflicting:	17. Object/Equipment/Substance/Inflicting:
12. Person with Most Control of Item # 11:	18. Person with Most Control of Item # 17:

DESCRIPTION
19. Describe clearly how the incident occurred:

ANALYSIS
20. What acts, failures to act and/or conditions contributed most directly to THIS ACCIDENT?
21. What are the basic or fundamental reasons for the existence of these acts and/or conditions?

PREVENTION
22. What action has or will be taken to prevent recurrence? Number all items in sequence:

23. Investigated by: Date:	24. Reviewed by: Date: