Bureau of Workers' Compensation

Consent to Release Information

Instructions

- Use this form if you want BWC to release information we have about your claim with another individual or organization.
- This signed consent applies specifically to this claim. You must file a separate consent form for each additional BWC claim you wish to release.
- If you need assistance, visit ohiobwc.com, or call BWC toll free at 1-800-OHIOBWC.

Injured worker

Injured worker name			Claim number
Date of birth	Phone number		
Address			
City		State	ZIP code

Information may include medical records, wages, compensation payments, allowed conditions and/or previous Industrial Commission of Ohio hearing orders.

☐ I authorize BWC to disclose documentation to the individual and/or organization listed below information regarding this claim.

☐ I authorize BWC to verbally communicate information about my claim with the individual listed below such as a family member or union representative.

Release information to

Name and/or organization			
Address			
City	State	ZIP code	Phone number

By signing below, I represent that I have the authority to sign this document, and I acknowledge the following:

- I understand the information included in my health and medical records may include sensitive information related to private health matters;
- I understand if HIV/AIDS is an allowed condition in my claim, my health and medical records may include information related to these conditions. Based upon this specific allowance, you must enter an ending date below to indicate the time this release will be effective, not to exceed 12 months from date of signature;
- I understand if a psychological condition is allowed in my claim, my health and medical records may include information related to these conditions;
- I understand BWC does not control the use of the released information once it has been disclosed to a recipient; any disclosure of information creates the potential for an unauthorized re-disclosure by the recipient; and that BWC expressly denies any liability for any consequences arising out of such disclosure;
- I understand I have a right to revoke this consent, verbally or in writing, at any time;
- I understand I can refuse to sign this consent, and I further acknowledge that I have executed this consent voluntarily and by my own free will.

This consent is valid until:

☐ 12 months from date of signature, or

☐ Specific date _____/_____/_____.

Signature of injured worker (or legal guardian, authorized representative, or executor, where applicable)	Date