



Workers' Compensation Board  
State of Oregon

In the Matter of the Request for Hearing of ) WCB Case No. \_\_\_\_\_  
\_\_\_\_\_) )  
\_\_\_\_\_) )  
\_\_\_\_\_) )  
\_\_\_\_\_) )  
\_\_\_\_\_) )

**SUBPOENA**

*To Compel the Production of  
Individually  
Identifiable Health Information<sup>1</sup>*

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**YOU ARE DIRECTED** to copy and send documents, including *Individually Identifiable Health Information*, concerning the following individual:

\_\_\_\_\_  
Claimant's Name

\_\_\_\_\_  
Claim No.

\_\_\_\_\_  
WCB Case No.

Documents to be sent: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Send Documents to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Issuer

*[ Continued ]*

<sup>1</sup> "Individually Identifiable Health Information" is: information which identifies an individual or which could be used to identify an individual, which has been collected from an individual and created or received by a health care provider, health plan, employer or health care clearinghouse; and which relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.

**I certify** that I delivered a copy of this subpoena

to \_\_\_\_\_  
(Custodian of records being subpoenaed)

at \_\_\_\_\_  
(Address)

on \_\_\_\_\_  
(Date)

by personal delivery or by certified mail return receipt requested.

**I also certify** that I mailed a copy of this subpoena

to \_\_\_\_\_  
(Individual or attorney of individual whose records are being subpoenaed)

at \_\_\_\_\_  
(Address)

on \_\_\_\_\_  
(Date)

By certified mail return receipt requested.

\_\_\_\_\_  
Signature Date

## NOTICE

### TO INDIVIDUAL WHOSE INDIVIDUALLY IDENTIFIABLE HEALTH RECORDS ARE BEING SUBPOENAED

IF YOU OPPOSE THE DISCLOSURE OF THE INFORMATION INCLUDED IN THIS SUBPOENA, YOU MUST FILE A WRITTEN OBJECTION WITH THE WORKERS' COMPENSATION BOARD, 2601 25<sup>TH</sup> STREET SE., SUITE 150, SALEM, OREGON 97302-1280. YOUR OBJECTION MUST BE FILED WITHIN TEN (10) CALENDAR DAYS OF THE MAILING DATE OF THIS NOTICE, AND MUST STATE THAT YOU OBJECT TO THE RELEASE OF THE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION, THE BASIS FOR YOUR OBJECTION, YOUR ADDRESS, AND THE DATE OF YOUR INJURY IF YOU KNOW THE DATE. A COPY OF YOUR LETTER MUST ALSO BE PROVIDED SIMULTANEOUSLY TO THE RECIPIENT OF THE SUBPOENA, AS WELL AS TO THE PARTY ISSUING THE SUBPOENA. IF YOU HAVE QUESTIONS YOU MAY CALL THE WORKERS' COMPENSATION BOARD TOLL-FREE IN OREGON 1-877-311-8061 OR, IN SALEM OR FROM OUTSIDE OREGON AT (503) 378-3308, OR THE OMBUDSMAN'S OFFICE AT (503) 378-3351, OR TOLL-FREE (800) 927-1271.

THE CUSTODIAN OF THE RECORDS SHALL PROVIDE THE RECORDS IN THE MANNER PRESCRIBED. THE RECORDS SHALL BE PROVIDED NO SOONER THAN 14 DAYS AFTER ISSUANCE OF THIS SUBPOENA, BUT NOT LATER THAN 21 DAYS AFTER ISSUANCE.

**NOTICE TO RECIPIENT OF SUBPOENA:** IF YOU RECEIVE A TIMELY OBJECTION FROM THE PARTY (OR THE PARTY'S ATTORNEY) WHOSE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION IS BEING SUBPOENAED, THE RECIPIENT SHALL COMPLY WITH THE SUBPOENA BY MAILING THE INFORMATION SOUGHT TO THE WORKERS' COMPENSATION BOARD, AT 2601 25TH STREET SE, SUITE 150, SALEM OREGON 97302-1280.