Client Name: _____

Project Name: _____

Contract No.: _____

Authorization for Release of Records Form

Employee & Claim Information

Employee Name (print full legal name):

SSN (Last 4 Only):	Date of Birth:	Date of Incident	Phone Number:

Purpose of Disclosure

☐ Workers' compensation claim administration ☐ Other:

Release of Records Request

Treating Doctor Name:	Medical Facility Name:

Facility Address:	Facility Phone #:

Scope of Authorization

I authorize the release of all information concerning care rendered to me for the work-related illness and/or injury identified above – including emergency room visits, diagnosis, diagnostic procedures and interpretations, medical history, exam reports, and pre-operative, operative, and post-operative reports – to the Company or its authorized representatives (including its workers' compensation carrier and third-party administrator) for the purpose(s) checked above.

This authorization is voluntary; my medical treatment and workers' compensation benefits are not conditioned on signing it. I may revoke it in writing at any time, except to the extent the Company has already relied on it. Unless revoked sooner, it expires 2 years from the date signed, or upon final resolution of the related claim, whichever is first. A photocopy, fax, or electronic copy of this authorization is as valid as the original.

Client Name: _____

Project Name: _____

Contract No.: _____

Employee / Patient Signature:

Print name: _____ Signature: _____Date: _____

A signature above is applied outside this form field: print and sign by hand, then scan/upload, or apply a digital signature to this PDF.

For HSE /HR use only:

Received by: _____ Date Received:_____

Contains confidential personnel/medical information. Handle per HSE record-retention policy.