

AUTHORIZATION FOR REHABILITATION PROFESSIONAL TO OBTAIN MEDICAL RECORDS OF CURRENT TREATMENT

IC File # _____
Emp. Code # _____
Carrier Code # _____
Carrier File # _____
Employer FEIN _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name _____			Employer's Name _____			() - _____ Telephone Number		
Address _____			Employer's Address _____			City State Zip		
City State Zip () - () -			Insurance Carrier _____					
Home Telephone _____			Work Telephone _____			Carrier's Address _____		
- -			<input type="checkbox"/> M <input type="checkbox"/> F / /			City State Zip () - () -		
Social Security Number _____			Sex Date of Birth			Carrier's Telephone Number _____		
						Fax Number _____		

I, _____, the employee-claimant, hereby authorize the
(Please Print)
release of all my medical records of treatment resulting from a work-related injury/occupational
disease that occurred/was contracted on _____ to the Rehabilitation
(Please Print)
Professional assigned to me. That Rehabilitation Professional is:

Name: _____
Address: _____
Telephone: _____

Employee's Signature _____ Date _____

NOTE: THE REFUSAL OF THE CLAIMANT TO SIGN THIS FORM UPON THE REQUEST OF THE REHABILITATION PROFESSIONAL MAY BE DEEMED BY THE INDUSTRIAL COMMISSION TO BE NONCOMPLIANCE WITH REHABILITATION AND MAY RESULT IN THE SUSPENSION OF BENEFITS.

PLEASE MAIL THIS COMPLETED FORM TO THE REHABILITATION PROFESSIONAL NAMED ABOVE.