North Carolina Industrial Commission

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 — City — State — Zip
Social Security Number - - — Sex ☐ M ☐ F — 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.

FORM 25C

NORTH CAROLINA INDUSTRIAL COMMISSION
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/