

AUTHORIZATION FOR REHABILITATION PROFESSIONAL TO OBTAIN MEDICAL RECORDS OF CURRENT TREATMENT

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

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

Employee's Name _____		Email Address _____		Employer's Name _____		Email Address _____		() - Telephone Number _____	
Address _____				Employer's Address _____		City _____		State _____ Zip _____	
City _____		State _____ Zip _____		Insurance Carrier _____					
() - Home Telephone _____		() - Work Telephone _____		Carrier's Address _____		City _____		State _____ Zip _____	
XXX-XX- Last 4 Digits of SSN _____		☐ M ☐ F Sex _____		I / I Date of Birth _____		() - Carrier's Telephone Number _____		Adjuster's Name _____ Email Address _____	

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.