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ILLINOIS COUNTIES RISK MANAGEMENT TRUST

**WORKERS COMPENSATION
INJURY MEDICAL AUTHORIZATION**

**AUTHORIZATION FOR MEDICAL RECORDS
AND COMMUNICATION RELEASE**

By this form or copy thereof, I _____, hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other related medical or medically related facility, insurance company or other organization, institution, or person, that has any records or knowledge of my mental or physical health, history, condition or well-being, to supply such information to my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment and as to my work injury or duties and ability to work. In conjunction with this, I also authorize any treating physician or medical provider to review any additional medical records provided to them.

A facsimile, e-mail or other electronic copy of this authorization shall be valid as the original. This release shall remain valid for the length of my claim.

Name (Please Print)

Address (Street, City/Town, Zip Code)

Signature

Date Signed

revised 11/13/00

