Authorization to Disclose Treatment History for Injury Claims

I hereby authorize the provider or facility named below to disclose my treatment history, including medical information related to my injury claim, as described below:

Patient Name

_____

Date of Birth

_____

Injury Date(s) (if known)

_____

Name of Provider or Facility

_____

Provider Address or Contact Information

_____

Information to be Disclosed

_____

(Describe the treatment history, documents, or information to be disclosed. Example: "Records relating to injury treatment from [date] to [date].")

Name or Entity Authorized to Receive Information

_____

I understand that this authorization is voluntary and that I may revoke it at any time by notifying the provider/facility in writing, except to the extent that action has already been taken in reliance on this authorization.

This authorization expires on _____ (if left blank, authorization will expire one year from the date below).

Signature of Patient

_____

Date

_____

If signed by a representative, describe relationship/authority:

A copy of this authorization is as valid as the original. You are entitled to a copy of this completed form.