Medical Authorization

The undersigned person(s) hereby consents to, and by the Authorization or any photocopy hereof authorizes, the release to the Workers Compensation Insurance Provider or Workers Compensation District Administrator for Caldwell County Schools any hospital, medical clinic, surgeon, physician, pharmacist or any other provider of medical services, treatment or supplies to

_____

(Name of Patient, Claimant)

Of any and all medical report, histories, findings, prognosis, diagnosis, bills, information or other documents relating to any medical treatment, hospitalization, prescription drugs or other medical services or supplies, including but not limited to psychiatric treatment, or treatment for alcoholism or drug abuse, of such patient for the last 10 years. Please list all physicians/hospital for the past 10 years.

The undersigned person(s) understands and hereby acknowledges that the information above or certain portions thereof, may be protected from disclosure without this signed Authorization by Federal and State privacy and confidentiality laws.

The Authorization shall automatically expire without express revocation one year after signature date below.

And prior to such time shall be subject to revocation with respect to all or any particular records at any time by the undersigned person(s) in writing delivered to the holder of such records except to the extent that action has already been taken in reliance upon this Authorization.

Date: _____

Claimant: _____
(Print Name)

Claimant: _____
(Signature)

Date: _____

Witness: _____
(Print Name)

Witness: _____
(Signature)