Orthopaedic Institute of Southern Illinois

Roland J. Barr, M.D.
Treg Brown, M.D.
Brian K. Daines, M.D.
J. Michael Davis, M.D.
John T. Davis, M.D.
Robert J. Golz, M.D.
Bret H. Miller, M.D.
Richard L. Morgan, M.D.
C. David Wood, M.D.
John B. Wood, M.D.
Steven D. Young, M.D.

WORKERS COMPENSATION
AUTHORIZATION FOR MEDICAL RECORDS AND COMMUNICATION RELEASE

I hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other 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 regarding my

(body or body parts)_____,

injury which occurred on (date)_____,

to my employer or employers insurance carrier, case manager, field nurse case manager, claims administrator or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer or its insurance company, claims administrator, rehabilitation or medical management consultant, case manager field nurse case manager or attorneys as to my care and treatment regarding my

(body or body parts)_____,

injury which occurred on (date)_____, and as to

any other issues including diagnosis, prognosis, causal connection of care and treatment to my work related injury or duties, and liability to work. I hereby waive my physician-patient privilege. In conjunction with this, I also authorize any treating physician or medical provider to review any additional materials provided to them.

A photocopy of this original shall be valid as the original. This release shall remain valid for the length of my claim.

_____
Name-Please Print

_____
Signature

_____
Date