AUTHORIZATION FOR MEDICAL RECORDS

By this form or a copy thereof, I hereby authorize any licensed physician, chiropractor, medical practitioner, 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 to medical representatives of my employer, its insurer, claim administrator or attorneys that is relevant to my injury of ____/____/____ (date). I revoke all other medical records release forms signed prior to this date.

A Photocopy of this authorization shall be as valid as the original. This release shall remain valid until revoked by me.

_____
Name-Please Print

_____
Signature

_____
Date