Consent for Release of Medical Information

Employee

I hereby authorize representatives of Insured Solutions to be permitted to obtain and review copies of all medical records related to any current or past injury or related to my medical history. Any pertinent information will be discussed with other professionals involved in my medical treatment and any institution that, through the "Workers' Compensation Program" or otherwise, is paying all or part of the costs associated with my medical care.

Employee's Printed Name

Social Security Number

Telephone Number

Claim Number

Name of Employer

Date of Injury

Employee's Signature: _____ **Date:** _____

If you have any questions or concerns, please feel free to call Insured Solutions Claims department or Loss Control.

Please fax completed form to (480) 289-6220 or email to WCNewClaims@InsuredSolutions.net.