

MEDICAL AUTHORIZATION

To Whom It May Concern:

The undersigned person hereby consents to, and by this authorization or any photocopy thereof, hereby authorizes the release to my employer or any agent or designee of my employer's insurance carrier and/or third party administrator, of any and all medical reports, histories, findings, prognosis, bills, information and other documents relating to any medical treatment hospitalization, prescription drugs, or other medical services or supplies, including psychiatric treatment or treatment for alcoholism or drug abuse of such patient.

The undersigned person understands that my employer and its agents, designees and insurance carrier/third party administrator, may, from time to time, find it necessary to obtain information verbally from my treating health care providers and such contact is hereby authorized.

The undersigned person understands and hereby acknowledges that the information above or certain portions thereof may be protected from disclosure without this signed authorization of federal and state privacy and confidentiality laws.

A photocopy of this authorization will serve as an original.

Patient Name: _____
(printed)

Social Security No.: _____

Date of Birth: _____

Patient Signature: _____ **Date:** _____