Name:
Chart:
Date:

GUILFORD ORTHOPAEDIC AND SPORTS MEDICINE CENTER

Workers' Compensation
Authorization Form to Release Information

Date of Injury: _____ Employer: _____

Insurer/Carrier: _____ File/Claim Number: _____

Pursuant to N.C. Gen Stat. 97-25.6:

I hereby voluntarily authorize Southeastern Orthopaedic Specialists, P.A. to communicate relevant medical information relating to my workers' compensation claim, including records of evaluation, treatment reports, prognosis, job restrictions of limitations, through oral, written, or electronic means, to my employer or its insurer/carrier, other health care providers, rehabilitation professionals/case managers, the North Carolina Industrial Commission, and other necessary parties, for purposes of: treatment; payment; bill procession; claims administration, scheduling of medical procedures, tests and studies; referrals; ability to return to work; job restrictions; and for all other activities necessary to process my workers' compensation claim.

Furthermore, I understand that this form is revocable; however, actions already taken by Southeastern Orthopaedic Specialists, P.A. in reliance on this authorization cannot be reversed, and revocation of this authorization will not affect those previous actions by will apply only from the time such written notice of revocation is received by Southeastern Orthopaedic Specialists, P.A.

_____ _____

Signature of Patient or Representative Date