Workers' Compensation Authorization Form to Release Information

Patient Information:

Name:_____ **Patient ID Number**:_____

Address:_____ **Date of Injury**:_____

_____ **Employer**:_____

_____ **Insurer/Carrier**:_____

Date of Birth:_____ **IC File 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 or 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 purpose of: treatment; payment; bill processing; claims administration, scheduling medical procedures, tests and studies; referrals; ability to return to work; job restrictions; and 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 but will apply only from the time such written notice of revocation is received by Southeastern Oethopaedic Specialists, P.A.

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Signature of Patient or Personal Representative Date