

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 Blue Ridge Orthopaedics & Sports Medicine 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 purposes of: treatment; payment; bill processing; 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 Blue Ridge Orthopaedics & Sports Medicine 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 Blue Ridge Orthopaedics & Sports Medicine.

Signature of Patient or Personal Representative

Date