Evergreen Family Health Partners
Workers Compensation Authorization for
Medical Record Release

Patient's Name_____ Date_____

Employer / Work Phone _____ Patient Social Security No._____

Employer Name_____

Employer Address_____

_____

Date of Injury_____ Brief Description of Incident _____

_____

Worker's Compensation Insurance Carrier Information:

Carrier Name:_____

Carrier Address:_____

Carrier Phone:_____

Claim #: _____

I authorize Evergreen Family Health Partners to release medical reports related to my illness or condition to the Workers Compensation Board, Employer and Insurance Carrier. In the event I fail to prosecute the claim for Workers Compensation for this illness or condition, or it is determined by the Workers Compensation Board that the illness or condition is not a result of a compensable workers compensation case, I hereby agree to pay Evergreen Family Health Partners the usual and customary fees for the services rendered.

AUTHORIZED SIGNATURE _____

DATE_____