AUTHORIZATION FOR MEDICAL RECORDS

By this form or a copy thereof, I hereby authorize any licensed physician, chiropractor, medical practitioner, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of my mental or physical health, history, condition or well-being, to supply such information to medical representatives of my employer, its insurer, claim administrator or attorneys that is relevant to my injury of ____/____/____ (date). I revoke all other medical records release forms signed prior to this date.

A Photocopy of this authorization shall be as valid as the original. This release shall remain valid as the original for the maximum duration or until revoked by me.

Duration

This authorization is valid during the duration of my claim. Release in connection with a claim for benefits for health insurance may not remain valid longer than the term of coverage of the policy; or for the duration of the claim for all other insurance claims.

NOTICE OF STATE FRAUD REQUIREMENTS

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

_____
Printed Name

_____
Signature

_____
Date