T2 INSURANCE SOLUTIONS LLC

YOUR WORKERS COMPENSATION SOURCE

Medical Information Release

I hereby authorize this company (_____)
to request and obtain all records regarding any work related accident, injury or occupational disease involving myself and the company.

This is to include –

- Test Results
- Medical Bills
- Nurse's Notes
- Doctor's Reports
- Follow-up Reports
- Work Releases

A facsimile or a photocopy of this authorization will be considered as effective and valid as the original.

I understand that I may revoke this authorization at any time. I further understand that if I revoke this authorization that I must do so in writing and present my written revocation to the treating facility.

Employee Signature: _____ Date:_____

Company Representative: _____ Date:_____