

Date:

Claim No.:

## **AUTHORIZATION FOR THE RELEASE OF INFORMATION**

Employee's Name:

Date of Birth:

Social Security Number: XXX-XX-

I, \_\_\_\_\_, hereby authorize any physician, chiropractor, medical practitioner, clinic, hospital, or other health care provider, including psychological or psychiatric care or evaluation, to release all medical reports or medically-related information concerning the diagnoses, prognoses, treatment, testing, findings, conclusions or other medically-related information and I, \_\_\_\_\_, hereby authorize any employer, current or former, to release all personnel records including but not limited to employee performance reports, disciplinary actions, reprimands, memos of concerns, corrective action plans, documented oral counseling, and present or past wage earnings.

This release authorization is given to the County of Kern or their properly identified representative for their use in the evaluation and handling of my claim.

I UNDERSTAND that any information obtained will not be released by County of Kern or their legal representatives to any person or organization which does not have an interest in the evaluation or other handling of my specific claim, or as may otherwise be lawfully required, or as I may further authorize.

I AGREE that this authorization shall be valid until the matter to which the requested information pertains has been concluded, including any appeal process.

I AGREE that a photographic copy or facsimile copy of this authorization shall be as valid as the original.

I UNDERSTAND that the authorized information includes, but is not limited to, matters pertaining to my industrial injury.

I HAVE BEEN advised of my right, upon request, to a copy of this authorization.

**DO NOT SIGN THIS FORM UNLESS YOU HAVE READ AND UNDERSTAND ALL OF THE PROVISIONS INCLUDED HEREIN.**

Signed this \_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Employee's Signature

Employee's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please list all medical providers, including addresses and phone numbers, who have treated you within the last ten (10) years:

<b>Medical Provider's Name:</b>	<b>Address/Telephone Number</b>