

UNIVERSITY OF ILLINOIS

Chicago • Springfield • Urbana-Champaign

Office of Claims Management
100 Trade Centre Drive, Suite 103
Champaign, IL 61820

AUTHORIZATION FOR MEDICAL AND HEALTH CARE INFORMATION

I, _____, hereby authorize any physician, hospital, clinic, medical attendant or other healthcare provider to furnish to my employer, its workers' compensation insurance carrier, its attorneys, or any representative thereof, any and all medical or healthcare information or opinions, which they request regarding my physical condition and treatment as it pertains to an injury which I am claiming is work related. This Authorization allows my employer, its workers' compensation carrier, its attorneys and their representatives to see or copy any x-rays, diagnostic tests or records that you may have regarding my condition or treatment. By signing this Authorization, I am authorizing my employer, its workers' compensation carriers, its attorneys and their representatives to contact any health care provider directly so as to request information, provide information, and to seek opinions with respect to my claim for benefits.

This Authorization shall remain in effect without time limitation until I rescind it, in writing, or such time as my claim is finally resolved by settlement or judgment. A copy of my written rescission must be sent to my employer. A photocopy of this Authorization shall be of equal effect to the original.

DATED THIS _____ DAY OF _____, _____.

Employee's Signature

Please complete information on the
back of this letter.

Name: _____

My first day of treatment for this condition was/will be: ____/____/____

Please list the names, addresses, zip code, phone and fax numbers for ALL treating medical facilities and Doctors.

1. _____

Phone _____

Fax _____

2. _____

Phone _____

Fax _____

3. _____

Phone _____

Fax _____

4. _____

Phone _____

Fax _____

5. _____

Phone _____

Fax _____

6. _____

Phone _____

Fax _____