Date: [Insert Date]

To: [Medical Provider Name/Facility Name]
[Address]
[City, State, Zip Code]

Re: Authorization for Release of Medical Information

Patient Name: [Employee Full Name]
Date of Birth: [Employee DOB]
Date of Injury: [Date of Incident]
Claim Number: [Insert Claim Number, if known]

To Whom It May Concern,

I hereby authorize [Medical Provider Name] to release medical records and information regarding my treatment for the workplace injury sustained on the date mentioned above to my employer, [Company Name], and their workers' compensation insurance carrier, [Insurance Carrier Name].

The scope of this release is limited to records relevant to the specific injury mentioned, including but not limited to:

- Diagnostic reports and imaging results
- Treatment plans and progress notes
- Work status reports and physical restrictions
- Prescription records related to the injury

This information is being used for the purpose of processing my workers' compensation claim and determining my fitness for duty or necessary workplace accommodations.

This authorization shall remain valid until [Date or Event] or until the conclusion of my workers' compensation claim, unless revoked by me in writing sooner.

Sincerely,

_____
[Employee Signature]

[Employee Printed Name]
[Phone Number]