

# AUTHORIZATION FOR REHABILITATION PROFESSIONAL TO OBTAIN MEDICAL RECORDS OF CURRENT TREATMENT

IC File# \_\_\_\_\_

Emp. Code # \_\_\_\_\_

Carrier Code # \_\_\_\_\_

Carrier File # \_\_\_\_\_

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employer FEIN \_\_\_\_\_

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

Employer's Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_

Carrier's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

M  F

Social Security Number \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Carrier's Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

I, \_\_\_\_\_, the employee-claimant, hereby authorize the  
(Please Print)

release of all my medical records of treatment resulting from a work-related injury/occupational  
disease that occurred/was contracted on \_\_\_\_\_ to the Rehabilitation  
(Please Print)

Professional assigned to me. That Rehabilitation Professional is:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

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

Date \_\_\_\_\_

**NOTE: THE REFUSAL OF THE CLAIMANT TO SIGN THIS FORM UPON THE REQUEST OF THE REHABILITATION PROFESSIONAL MAY BE DEEMED BY THE INDUSTRIAL COMMISSION TO BE NONCOMPLIANCE WITH REHABILITATION AND MAY RESULT IN THE SUSPENSION OF BENEFITS.**

**PLEASE MAIL THIS COMPLETED FORM TO THE REHABILITATION PROFESSIONAL NAMED ABOVE**

MAIL TO:

**NORTH CAROLINA INDUSTRIAL COMMISSION  
4340 MAIL SERVICE CENTER  
RALEIGH, NC 27699-4340  
MAIN TELEPHONE: (919) 807-2500  
OMBUDSMAN: (800) 688- 8349**