

(AUTHORIZATION FOR MEDICAL RELEASE INFORMATION)

BWC LOGO

(Project Use Only - Corr20A)

mm/dd/yy

ADDRESSED TO:
(Injured Worker)

Injured Worker:

Claim Number:

Injury Date:

Claim Type:

Employer Name:

Policy Number:

Employer Status:

MCO Name:

MCO Number:

Social Security #:

The injury(s)/ICD code(s) allowed in this claim are:

ICD	Description	Body Location	Part of Body
<XXX.XX>	<Narrative Description>	<Body Location>	<Part of Body>

The injury(s)/ICD code(s) currently being reviewed to determine allowance are:

ICD	Description	Body Location	Part of Body
<XXX.XX>	<Narrative Description>	<Body Location>	<Part of Body>

I, the above named injured worker, understand that I am allowing any person or facility that attends, treats or examines me to release all medical, psychological, and/or psychiatric information that is related to my workers' compensation claim.

This information will be available to the Ohio Bureau of Workers' Compensation (BWC) or their agent, the Ohio Industrial Commission, and the above named employer, upon request.

I understand that a copy of the medical information received by the employer will be forwarded to the BWC, by the employer.

I also understand that a copy of the medical information will be available to me or my physician of record upon request to BWC, the employer or provider.

Injured Worker's Signature

Date