



Injured worker

Form with fields: Name, Date of birth, Claim number, Address, City, State, ZIP code, Phone number

Records requestor

Form with fields: Name, Business name, Address, City, State, ZIP code, Phone number, Fax number, E-mail address

Specific Information Authorized

- I authorize BWC to disclose to the above-named individual and/or organization, records, information and/or data (selected below) regarding any and all of my BWC claims.
I authorize BWC to disclose to the above-named individual and/or organization, records, information and/or data (selected below) regarding the following BWC claim(s):

- Complete claim file(s)
Wages/payments
Claim status
Medical billing history
Industrial Commission of Ohio orders
Other
Medical records

By signing below, I represent that I have the authority to sign this document, and I acknowledge the following:

- I understand the information included in my health and medical records may include sensitive information related to private health matters;
I understand BWC does not control the use of the released information once it has been disclosed to a recipient; any disclosure of information creates the potential for an unauthorized re-disclosure by the recipient; and that BWC expressly denies any liability for any consequences arising out of such disclosure;
I understand this authorization is only valid for one year from the date of signature;
I further understand I have a right to revoke this authorization at any time;
I understand I can refuse to sign this authorization, and I further acknowledge that I have executed this authorization voluntarily and by my own free will.

Signature of injured worker (or legal guardian, authorized representative, or executor, where applicable) Date