AUTHORIZATION FOR
DISCLOSURE OF INFORMATION

I, DO HEREBY AUTHORIZE ____
(Treatment Providers / Hospitals / employers / Schools / …)

to disclose, discuss with and/or provide reports to authorized representatives of *Mohawk Self Insurance* pertaining to:

- **x** **MEDICAL INFORMATION:** **Including discussing, reviewing, inspecting and making copies of any and all medical records including pre-existing medical information. This includes all testing, date or information in possession as well as providing diagnosis, prognosis, treatment plans, etc. concerning the injuries and/or illnesses dating of ________ (date of injury/illness)**
- ☐ **EMPLOYMENT INFORMATION:** **Including contacting my current / previous or prospective employers(s); discussing, reviewing, inspecting and making copies of any employment records; sharing information pertaining to vocational status and return to work abilities.**
- ☐ **EDUCATION INFORMATION:** **Including contacting my current or previous Academic Institutions) / Schools(s); discussing, reviewing, inspecting and making copies of any and all academic records.**

As it pertains to: ____
(claimant) **(date of birth)**

I understand that the information obtained pursuant to this release may be disclosed to :

____
(Insurance Company/Legal Representative/Employer)

In addition, I understand the information may be shared by *Mohawk Self Insurance* to relevant parties for the purpose of Medical and/or Vocational Rehabilitation Services.

A photocopy of this authorization may be accepted with the same authority as the original.

I have read the above authorization and express my consent by affixing my signature:

________________________________ ____________________________
(Claimant / Authorized Person) **(Date)**

____
(Relationship if other than Claimant)

____
(Witness)