

NCDOT WORKERS' COMP RELEASE OF INFORMATION

TO WHOM IT MAY CONCERN:

EMPLOYEE: _____
PRINT NAME HERE

A Workers' Compensation claim (Form 19) has been filed on my behalf. I recognize that as part of the claim examination and claim processing procedures various inquiries shall be made of healthcare providers, medical facilities, the NC Industrial Commission and other individuals and agencies as required.

Therefore, I authorize the release of any and all information regarding: my medical/mental health condition, medical/mental health treatment, previous medical/mental health history (including any pre-existing conditions) relevant to this claim, and any previous workers' compensation injuries or claims whether reported or not to the Industrial Commission, or any other State or Federal agency.

STATEMENT:

I have read the above statement/authorization and voluntarily give my consent to obtain such records and/or information as requested by an authorized representative of the NC Department of Transportation. I understand that this information will be kept strictly confidential (unless legal requirements necessitate its release) and will be gathered only in conjunction with a Workers' Compensation claim examination or claim processing function.

Employee signature/release

Supervisor or Witness signature

Date

Date