MEDICAL AUTHORIZATION

TO WHOM IT MAY CONCERN:

NAME OF CLAIMANT: ____

DATE OF ACCIDENT: ____

I hereby authorize you to disclose to Rockwood Casualty Insurance Company, and to permit Rockwood Casualty Insurance Company to obtain and review, any records, notes and information relating to me, including but not limited to:

> Any evaluations, diagnoses, testings, treatments, services, supplies or equipment furnished by you in connection with any illness or injury sustained by me on or about the date of accident and any prior related information as may be requested.
>
> Any hourly, weekly, monthly or other wages, salaries, commissions, or remuneration in connection with my employment with your company.

Please provide the requested health information from the onset of the illness or injury through the duration of treatment and such prior relevant information as may be requested.

I hereby authorize Rockwood Casualty Insurance Company to obtain, use, examine, analyze and disclose the information obtained pursuant this Authorization for the purposes of determining my eligibility for and the amounts of workers' compensation benefits. I further authorize you to discuss my return to work status and the requested health information with Rockwood Casualty Insurance Company and/or its designated representative(s).

I agree that a copy of this Authorization shall be considered as effective and valid as the original. This Authorization shall remain effective and valid until revoked by me. I understand that such a revocation may affect my eligibility for workers' compensation benefits.

Signature of Claimant ______________________________ **Date** ____________________