

7. I understand that information to be released pursuant to a work-related/occupational injury or illness/workers' compensation claim may also be released to WCA and its current medical cost containment contractor or their duly authorized agents.

8. I hereby expressly waive any regulations and/or rules of ethics that might otherwise prevent any hospital, health care provider or other person who has treated me or examined me in a professional capacity from releasing such records.

9. A photostatic or other copy of this Release, which contains my signature, shall be considered as effective and valid as the original, and shall be honored by those to whom it is sent or provided for a period of six (6) months from the date it was signed.

10. This Release does not authorize any personal or telephonic conferences or correspondence directly between any health care provider and a representative of my employer, its attorney or insurance carrier to discuss my case and is solely for the release of medical documentation as set forth herein. Brief communication for the limited purpose of obtaining medical records is permitted.

11. I understand I am entitled to a copy of this authorization and to any records provided hereunder. I am requesting a copy of this authorization Yes No - If Yes, I have received a copy _____ (initial)
I understand this authorization will expire within six (6) months of the date I signed it, unless I revoke it earlier, pursuant to Paragraph 5.

Signature of Employee _____ **Date** _____

Personal Representative Section:

If a personal representative executes this form, that representative warrants that he or she has authorization to sign this form on the basis of (print detailed basis for representation): _____
_____.

Signature of Personal Representative _____ **Date** _____