

Consent for Release of Medical Information

I hereby authorize representatives of Patriot Risk Services to be permitted to obtain and review copies of all medical records related to my workers' compensation injury. This pertinent information will be discussed with other professionals involved in my medical treatment and any institution that, through the "Workers' Compensation Program" or otherwise, is paying all or part of the cost associated with my medical care.

Name of Employee

Social Security Number

Claim Number

Telephone Number of Employee/Email address

Name of Employer

Date of injury

Signature of Employee

Date

Submit to:

Patriot Risk Services
PO Box 2159
Fort Lauderdale, FL 33303
Fax: (954) 252-3816

A PHOTOCOPY OR FACSIMILE COPY OF THIS AUTHORIZATION IS AS VALID AS
THE ORIGINAL.