



**AUTHORIZATION FOR
MEDICAL RECORDS & COMMUNICATION RELEASE**

I authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or other organization, institution or person, that has any records of or knowledge of my mental or physical health, history, condition or well-being to supply such information to my employer (Village of Bloomingdale), the Intergovernmental Risk Management Agency (IRMA), or their attorneys.

I specifically authorize any treating physician or medical care provide to communicate orally or in writing with my employer, IRMA as claims administrator, their rehabilitation and/or medical management consultants or their attorneys, as to my care and treatment, and as to any other issues including, but not limited to; diagnosis, prognosis, causal connection of care and treatment to my work injury or duties; and ability to work. I hereby waive my physician-patient privilege. In conjunction with this, I also authorize any treating physician or medical provider to review any additional material provided to them.

A photocopy of this authorization shall be as valid as the original. This release shall remain valid for the length of my claim.

Name (Please Print)

Signature

Date