

Authorization for Release of Medical Information

I, _____, authorize any holder of medical information about me to release to The Shelby County Risk Management Department any information needed for any On The Job Injury Conditions, Injuries, Or Claims.

The holder of this "Authorization For Release Of Medical Information" is also authorized to release any medical information and/or medical reports to any medical provider engaged by Shelby County Government to be used to evaluate any on the job injuries, conditions, or claims.

I also permit a copy of this authorization to be used in place of the original.

This authorization shall remain valid unless canceled by me in writing, and acknowledged by the Shelby County Government Risk Management Department.

Witness:

Date:

Signature:

Date: