Employee Authorization for the Release of Medical Information

My employer, East Carolina University, participates in the NC State Government Workers' Compensation Program administered by the NC Office of State Human Resources. I understand that claim examination and management shall require the release of certain information regarding this claim for distribution, to necessary, healthcare providers, third party claim management administrators, and any other necessary agency.

Therefore, I hereby authorize any physician, dentist, chiropractor, therapist, clinic, hospital, other health care provider or administrative staff, to release any and all medical records to **ECU Environmental Health and Safety Office**, related to my examination, evaluation, and/or treatment beginning _____, including but not limited to, the following:
(*Date of Injury*)

1. All progress reports and summaries;
2. All clinical records;
3. Results of all laboratory tests, including x-rays;
4. Records of all prescribed medications and treatments;
5. All correspondence between my doctors or their administrative staffs or the administrative staffs of all hospitals, clinics, or other medical treatment centers where I am, or have been, a patient or from whom I received medical care;
6. All correspondence either by facsimile, electronic mail or hard copy between my doctors or their administrative staffs, or the administrative staffs of all hospitals, clinics, or other medical treatment centers where I am, or have been, a patient or from whom I have received medical care, and any insurance companies or their representatives concerning any claims made on my behalf for medical treatment or for benefits of any nature including, but not limited to, disability benefits, social security benefits, and Veteran's Administrative benefits;
7. All correspondence of whatsoever nature concerning any worker's compensation claims filed on my behalf;
8. All statements rendered for medical services and supplies;
9. All notes, correspondence, or other records of any nature made by my physicians, nurses, or any other persons concerning me, my condition, or my treatment.

An electronic, photocopy, or faxed copy of the "Authorization for Release of Medical Information" shall have the same force and effect as the original and shall be sufficient for the same purposes.

_____
Employee Print

_____ _____
Employee Signature *Date*

_____ _____
Witness Signature *Date*