EMPLOYEE RELEASE OF INFORMATION
MEDICAL AND CLAIM RECORDS

To Whom It May Concern:

My employer filed an Employer's Report of Employee's Injury to the North Carolina Industrial Commission (Form 19) for an injury I reported that occurred on _____.
(insert date of injury)

My employer participates in the North Carolina State Government Workers' Compensation Program administered by the NC Office of State Human Resources.

I understand that claim examination and claim processing procedures shall require release of certain information regarding this claim for distribution, as necessary, to the North Carolina Industrial Commission, state contractors, agencies, healthcare providers and other individuals.

Therefore, I hereby authorize release of any and all information for review, examination, copying and distribution regarding:

1. Pre-existing or current medical/mental health condition(s), pre-existing or current medical/mental health treatment(s), or any other medical/mental health treatment related to this claim.
2. Any previous workers' compensation injuries or claims whether reported or not to the North Carolina Industrial Commission, or any other State or Federal agency.

I understand state contractors, agencies, healthcare providers and other individuals may communicate this information by any reasonable means, including written or telephonic communication or by direct interview, whether or not I am present during or notified of such communications, and I authorize, to initiate and conduct such communications whether or not I am present or have notice thereof.

I understand that this information will be kept strictly confidential unless legal requirements necessitate its release and will be gathered solely for purposes related to this workers' compensation claim.

An electronic of faxed copy of this document shall have the same effect as the original.

Employee Name (Print)	**Employing Agency**
Employee Signature	**Supervisor or Witness Signature**
Date	**Date**