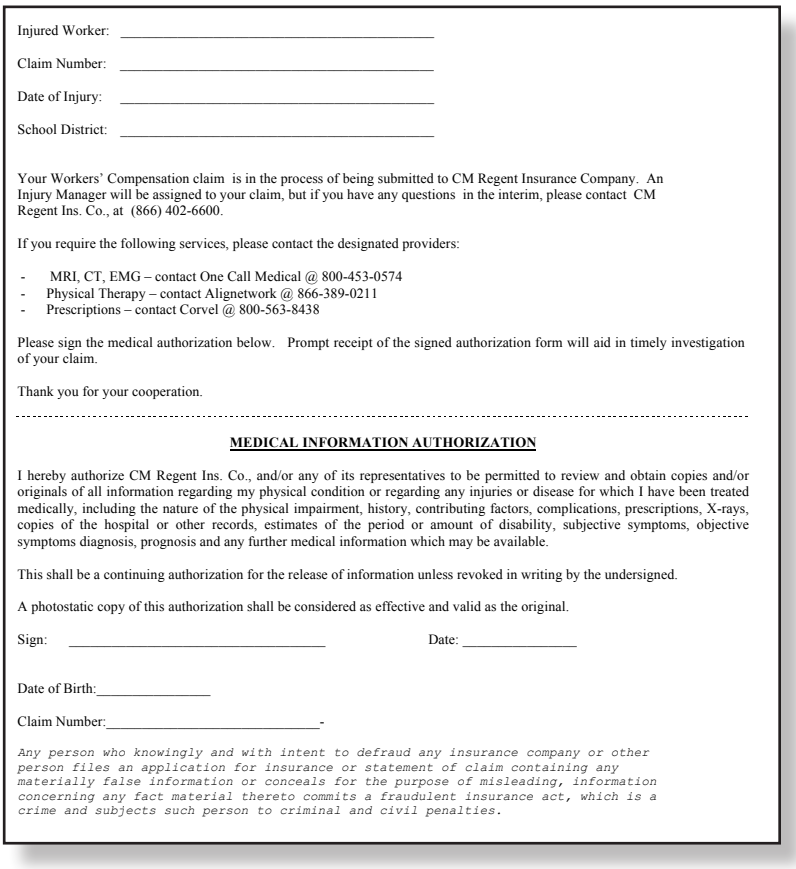
Medical Authorization Form

WHAT IS IT: Form signed by Injured Worker at time of injury in order to secure medical records and be able to speak to the treating medical providers

IMPORTANCE: Allows for more timely request for medical records (pre and post injury) thus allowing a more thorough investigation of the claim.

HOW FORM IS TO BE USED: Upon notification of an injury, provide form to Injured Worker (IW) for review and signature. Fax to CM Regent Ins. Co. (866-402-6601) upon receipt of on-line claim referral (which will provide claim number).



Injured Worker: _____

Claim Number: _____

Date of Injury: _____

School District: _____

Your Workers' Compensation claim is in the process of being submitted to CM Regent Insurance Company. An Injury Manager will be assigned to your claim, but if you have any questions in the interim, please contact CM Regent Ins. Co., at (866) 402-6600.

If you require the following services, please contact the designated providers:

- MRI, CT, EMG – contact One Call Medical @ 800-453-0574
- Physical Therapy – contact Alignetwork @ 866-389-0211
- Prescriptions – contact Corvel @ 800-563-8438

Please sign the medical authorization below. Prompt receipt of the signed authorization form will aid in timely investigation of your claim.

Thank you for your cooperation.

MEDICAL INFORMATION AUTHORIZATION

I hereby authorize CM Regent Ins. Co., and/or any of its representatives to be permitted to review and obtain copies and/or originals of all information regarding my physical condition or regarding any injuries or disease for which I have been treated medically, including the nature of the physical impairment, history, contributing factors, complications, prescriptions, X-rays, copies of the hospital or other records, estimates of the period or amount of disability, subjective symptoms, objective symptoms diagnosis, prognosis and any further medical information which may be available.

This shall be a continuing authorization for the release of information unless revoked in writing by the undersigned.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Sign: _____ Date: _____

Date of Birth:_____

Claim Number:_____-

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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