MEDICAL INFORMATION RELEASE FORM

EMPLOYEE NAME:_____

DATE OF INJURY:_____

CLAIM NUMBER:_____

I understand that the Industrial Commission of Ohio Rule 4121-17-30(L) requires me to provide a signed medical release to my employer upon request.

By signing this release, I expressly waive all provisions of law, which forbid any person (or persons or medical facility who did or will treat, examine, or may have information useful of necessary for the resolution of issues in the administration of my workers' compensation claim) from disclosing such information to my employer or its representative.

Employee Signature: _____

Date:_____