

**AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORD INFORMATION**

**EMPLOYEE**

**NAME:** \_\_\_\_\_ **Z#** \_\_\_\_\_  
**Please Print**

**DATE OF INJURY/ILLNESS:** \_\_\_\_\_

I hereby authorize LANL Occupational Medicine (ESH-2) and other health care physicians and/or institutions to discuss information on the above work related injury/illness with each other and with Risk Management/Workers' Compensation Office staff and its Third Party Administrator, Occupational Healthcare Management Services.

I understand that I have the right to ask for and receive a true copy of this Authorization signed by me and that a reproduced copy of the Authorization will be as valid as the original.

I further understand that by NOT signing this release, my Medical and Workers' Compensation Benefits will not be affected.

**Worker's**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_

**THIS FORM CANNOT BE ACCEPTED WITHOUT A WITNESS SIGNATURE**

**September 7, 1999**