FORT WORTH

TO: City of Fort Worth
Human Resources Department
Risk Management Division / Workers' Compensation Section

RE: AUTHORIZATION TO RELEASE MEDICAL INFORMATION

DEAR RECORDS CUSTODIAN:

This is to serve as my written consent for the release of confidential medical information, files and records regarding _____ pursuant to Section 5.08(j) of the Medical Practice Act.
Name of Employee / Claimant

The following City of Fort Worth Divisions and their contract service providers for workers' compensation and employee health benefits services are hereby authorized and released to obtain and distribute as necessary any and all past medical information in its (their) files, medical records, x-rays and reports concerning _____ and my medical history, diagnoses, treatments,
Name of Employee / Claimant
and prognoses, past, present and future.

City of Fort Worth, Risk Management Division / Workers' Compensation Section
Service Providers: York Risk Services; WellComp

City of Fort Worth, Employee Benefits Division
Service Providers: Aetna; UnitedHealthCare

The purpose for this release is that I,_____ have made a claim workers'
Name of Employee / Claimant
compensation benefits under Texas laws for injuries related to my claim dated _____. The
date of injury
medical records are considered necessary to evaluate my injuries and claims made in said workers' compensation claim as well as my medical and/or physical condition prior to the injury.

The costs of copying said medical records, if any, shall be the sole responsibility of the City of Fort Worth, Risk Management Division / Workers' Compensation Section, 1000 Throckmorton Street, Fort Worth, Texas 76102.

I reserve the right to withdraw my consent to this release of information at any time in writing to the Risk Management Division / Workers' Compensation Section. However, subsequent withdrawal of this consent does not affect any information disclosed prior to the City of Fort Worth's receipt of my written notice of withdrawal.

A photostatic or electronic copy of this release may be treated as an original.

Signed this _____ day of _____, 201__.

_____
AUTHORIZED SIGNATURE, Employee / Claimant

_____
Claimant's Attorney (if represented)

_____
Printed Name

_____
Social Security Number

_____
Address

_____
City State Zip Code