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**WORKMAN'S COMPENSATION
RECORDS RELEASE AUTHORIZATION**

I hereby authorize you to release information regarding my injury or illness associated with my employment that occurred on the date of _____ while I was in the employ of:

Employer Name _____

Employer Address _____

Employer Phone _____ Contact _____

The information may be released to my employer and to my employer's workman's compensation insurer and any governmental agencies affiliated with workman's compensation regulation and administration.

I understand that if it is determined that this was not a workman's compensation injury or illness, I may be held financially responsible for expenses incurred for services provided or ordered by this facility and its providers.

Signed _____ Date _____

Printed Name _____

Address _____

Birth date _____ Soc Sec # _____

Witness _____ Date _____

FOR BFMC OFFICE USE ONLY:

Ph# called _____ Date _____

Contact _____ Time _____

Send claims to _____

Notes _____