5409 White Blossom Drive
Greensboro, NC 27410

T: 336-644-9661
F: 1-888-268-1042

E: info@cedarhillpt.com
www.cedarhillpt.com

Workers' Compensation Authorization Form to Release Information

Patient's name: ______________________________

Patient ID Number: ______________________________

Address: ______________________________

Date of Injury: ______________________________

Employer: ______________________________

Insurer/Carrier: ______________________________

Date of Birth: ______________________________

IC File Number: ______________________________

Pursuant to N.C. Gen. Stat. 97-25.6:
I hereby voluntarily authorize Cedar Hill Physical Therapy to communicate relevant medical information relating to my workers' compensation claim, including records of evaluation, treatment reports, prognosis, job restrictions or limitations, through oral, written, or electronic means, to my employer or its insurer/carrier, other health care providers, rehabilitation professionals/case managers, the North Carolina Industrial Commission, and other necessary parties, for purpose of: treatment; payment; bill processing; claims administration, scheduling medical procedures, tests and studies; referrals; ability to return to work; job restrictions; and all other activities necessary to process my workers' compensation claim.

Furthermore, I understand that this form is revocable; however, actions already taken by Cedar Hill Physical Therapy in reliance on this authorization cannot be reversed and revocation of this authorization will not affect those previous actions but will apply only from the time such written notice of revocation is received by Cedar Hill Physical Therapy.

______________________________ ______________________________

Signature of Patient or Personal Representative Date