

# Consent for Release of Medical Information

## Employee

I hereby authorize representatives of Human Capital to be permitted to obtain and review copies of all medical records related to any current or past injury or related to my medical history. Any pertinent information will be discussed with other professionals involved in my medical treatment and any institution that, through the "Workers' Compensation Program" or otherwise, is paying all or part of the costs associated with my medical care.

\_\_\_\_\_  
**Employee's Printed Name**

\_\_\_\_\_  
**Social Security Number**

\_\_\_\_\_  
**Telephone Number**

\_\_\_\_\_  
**Claim Number**

\_\_\_\_\_  
**Name of Employer**

\_\_\_\_\_  
**Date of Injury**

**Employee's Signature:** \_\_\_\_\_

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

If you have any questions or concerns, please feel free to call Human Capital's Claims department or Loss Control.

**Please fax completed form to (480) 289-6220 or email to [WCNewClaims@Human-Capital.com](mailto:WCNewClaims@Human-Capital.com)**