

**STATE OF ILLINOIS
WORKERS' COMPENSATION CLAIM
INFORMATION RELEASE AUTHORIZATION
ASSOCIATED WITH AN INCIDENT OF:**

(Date)

I, the undersigned, do hereby authorize any physician, psychologist, psychiatrist, dentist, hospital or other medical provider to furnish all records, reports, histories, diagnostic tests and evaluation, physician and nurses notes and therapy notes in their possession regarding diagnosis and prognosis for my injuries and opinions regarding the nature, extent, causation, etiology and development of my injuries for the purpose of adjudicating a Workers' Compensation claim to my employer, the State of Illinois or to the Office of the Attorney General. I hereby waive any HIPAA requirements associated with the adjudication and administration of this Workers' Compensation claim. Subject to the terms and limitations set forth herein, I also consent to the use of such information to facilitate efforts of medical case management and rehabilitation/vocational services to assist with my return to work. A photocopy of this authorization shall be considered as effective and valid as the original regardless of the date hereon.

Claimant Signature

Social Security Number

Witness to Signature

Date

CFN

Date of Injury

Agency/University/Facility

Work Comp Coordinator