**RELEASE OF MEDICAL RECORDS**

DATE: April 12, 2017

EMPLOYEE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF INJURY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLAIM NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To Whom It May Concern: I, the undersigned, \_\_\_\_\_\_\_\_\_\_\_, do hereby request and authorize

any medical health care provider, upon presentation of this authorization, to speak with and

disclose to Facility Solutions Group, Inc. or its representative, any material or information

concerning Full Name with respect to illness or injury, medical history, consultation, treatment

including but not limited to x-rays, medical histories, nurses’ notes, prescriptions and copies of

all hospital or medical records. A photostatic copy of this authorization shall be considered as

effective and valid as the original.

This is not a release of any claim I may have.

NAME SIGNED

DATE

STREET/ADDRESS CITY STATE ZIP CODE