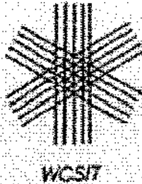
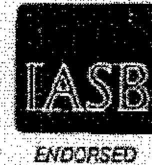


AUTHORIZATION FOR MEDICAL RECORDS AND REPORTS



DATE:____________________

TO WHOM IT MAY CONCERN:

1. The undersigned hereby directs and authorizes (a) any physician, nurse or any other medical practitioner who treated, examined and/or attended me, or (b) any hospital, clinic or medical facility at which I have been treated, examined, attended and/or confined, to verbally confer with and to furnish to any employee, agent, representative or attorney of Hinz Claim Management, INC., all information or opinions pertaining to or concerning the past, current, or future physical, medical or psychological treatment and/or condition of me including, without limitation, any recommendations regarding further care and my ability to perform job duties. This authorization permits the release of any and all records, documents, papers, opinions or statements, whether written or oral, concerning any examination, diagnosis, treatment, periods or stays of hospitalization or other confinements.

2. I understand that the purpose of this authorization is to allow Hinz Claim Management, Inc. to investigate and/or administer claims or potential claims, past, current, or future, for benefits under the Illinois Workers' Compensation or Occupational Diseases Acts. I further understand that this authorization constitutes an express waiver of the patient-physician privilege.

3. A copy of this authorization may be used in place of, and with the same force and effect as, the original. This authorization or any copies thereof shall remain in effect unless and until you receive written notice from me revoking your authority to release the above listed information. This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date it is signed.

____________________________ ____________________

Signature Date