AUTHORIZATION TO RELEASE MEDICAL INFORMATION

RE: EMPLOYEE:
EMPLOYER:
CLAIM #:
D.O.I.:

This authorization to release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1980, Section 56 et scy. of the California Civil Code.

I hereby authorize the following physicians, healthcare practitioners, hospitals or other medical or medically-related facilities to provide to York Insurance Services Group, Inc, or an agent of York Insurance Services Group, Inc, any and all records pertaining to medical history, services rendered or treatment given to me for purposes of review, investigation or evaluation of the above workers' compensation claim.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

This authorization shall become effective immediately and shall remain in effect as long as necessary for York Insurance Services Group, Inc to complete its investigation of the above workers' compensation claim.

I understand that the same restrictions for release of medical information apply to York Insurance Services Group, Inc as to the above listed medical providers and that no further authorization is made than is specifically indicated in this form. I further understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received: _____ Yes _____ No Initial: _____

Signature: _____ **Date:** _____
Witness: _____

Please sign and return to:

York Insurance Services Group, Inc
PO Box 619079
Roseville, CA 95661