MEDICAL INFORMATION RELEASE AUTHORIZATION

TO WHOM IT MAY CONCERN:

IN RE: Claimant's name _____
SS Number _____
Date of Birth _____

For the purposes of Workers' Compensation claim adjudication, you are hereby authorized and directed to furnish to the South Carolina School Boards Insurance Trust, or to its representative, adjuster, attorney or other agent, any and all information in your possession, or under your control relating to my medical or dental care, including but not limited to the following:

(a) Hospital records, x-rays, x-ray readings and reports, laboratory records, pharmacy records, and reports, all tests of any type or character, and reports thereof, statement of charges, and any and all of my records pertaining to hospitalization, history, condition, treatment, diagnosis, prognosis, etiology or expenses:

(b) Medical, dental, psychological, psychiatric, pharmacy, or chiropractic records, including patient's record cards, nurses and doctor's daily notes, x-rays, x-ray readings and reports, laboratory records and reports thereof, statements of charges, and any and all of my records pertaining to medical care, history, condition, treatment, diagnosis, prognosis, etiology or expense.

You are further authorized and directed to furnish oral and written reports and information to the South Carolina School Boards Insurance Trust, its representative, adjuster, attorney or other agent, as requested by it on any of the foregoing matters, and to allow it to review any records relating to my workers compensation claim or to confer with it concerning my workers' compensation claim.

The patient understands that the information disclosed pursuant to this authorization may be subject to re-disclosure for investigative purposes and/or medical referrals, opinions, and decision-making related to my care.

***The signed authorization shall not expire, and shall not be revoked so long as the claim for Workers' Compensation benefits is open and/or actively pursued, unless otherwise determined by lawful agreement.**

*Date:_____ _____
PATIENT/CLAIMANT SIGNATURE

NOTE: A photocopy of this authorization shall have the same effect as the original.