



AUTHORIZATION FOR RELEASE OF INFORMATION

Patient: _____

TO WHOM IT MAY CONCERN:

You are hereby expressly authorized to release and furnish to the State Office of Risk Management (SORM), and/or any associate, assistant, representative, agent, or employee thereof, any and all desired information (including, but not limited to, office records, medical reports, memos, hospital records, laboratory reports, including results of any and all tests including alcohol and/or drug tests, X-rays, X-ray reports, including copies thereof) pertaining to the physical and/or mental condition which is the basis of my workers' compensation claim. This includes not only all current and/or future information, but also all past medical information which is related to the injury or injuries which form the basis of my claim.

(Print name) _____

SIGNED: _____ DATED: _____

Copies of this signed authorization will be considered just as valid as the original. This is not a release of claims for damages.

PLEASE SIGN THE ABOVE MEDICAL AUTHORIZATION AND RETURN IT, SO WE MAY SECURE RELEASE OF YOUR MEDICAL RECORDS.

THANK YOU.

State Office of Risk Management
PO Box 13777
Austin, TX 78711-3777
(512) 475-1440
Fax: (512) 370-9025