



8. I hereby expressly waive any regulations and/or rules of ethics that might otherwise prevent any hospital, health care provider or other person who has treated me or examined me in a professional capacity from releasing such records.

9. A photostatic or other copy of this Release, which contains my signature, shall be considered as effective and valid as the original, and shall be honored by those to whom it is sent or provided for a period of six (6) months from the date it was signed.

10. This Release does not authorize any personal or telephonic conferences or correspondence directly between any health care provider and a representative of my employer, its attorney or insurance carrier to discuss my case and is solely for the release of medical documentation as set forth herein. Brief communication for the limited purpose of obtaining medical records is permitted.

11. I understand I am entitled to a copy of this authorization and to any records provided hereunder. I am requesting a copy of this authorization  Yes  No – If Yes, I have received a copy \_\_\_\_\_ (initial)  
I understand this authorization will expire within six (6) months of the date I signed it, unless I revoke it earlier, pursuant to Paragraph 5.

**Signature of Employee** \_\_\_\_\_ **Date** \_\_\_\_\_

**Witness Signature (REQUIRED)** \_\_\_\_\_

**This form cannot be accepted without a witness signature.**

Witness Name (Print or type) \_\_\_\_\_ **Date** \_\_\_\_\_

**Personal Representative Section:**

If a personal representative executes this form, that representative warrants that he or she has authorization to sign this form on the basis of (print detailed basis for representation):

\_\_\_\_\_  
**Signature of Personal Representative** \_\_\_\_\_ **Date** \_\_\_\_\_