MEDICAL AND WORKERS' COMPENSATION CLAIM AUTHORIZATION

Claim Number:

Insured:

Injured Worker:

Date of Injury:

Date of Birth:

SSN:

I authorize any licensed physician, medical practitioner, pharmacist, psychiatrist, psychologist, or other mental health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to Michigan Commercial Insurance Mutual to which I am submitting a claim, or to its legal representative.

I understand the information obtained by use of the authorization will be used by Michigan Commercial Insurance Mutual to determine eligibility for insurance benefits. Any information obtained through this authorization will be released as necessary for the processing of my claim, including any proceedings arising out of my claim.

I know that I may request a copy of this authorization.

I agree that a photographic copy of this authorization shall be as valid as the original.

I agree this authorization shall be valid during the life of my claim.

_____

Signature of Injured Worker or Authorized Representative

_____

Date