Consent for Release of Medical Information

Employee

I hereby authorize representatives of Star HRO to be permitted to obtain and review copies of all medical records related to any current or past injury or related to my medical history. Any pertinent information will be discussed with other professionals involved in my medical treatment and any institution that, through the "Workers' Compensation Program" or otherwise, is paying all or part of the costs associated with my medical care.

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Employee's Printed Name

____

Social Security Number

____

Telephone Number

____

Claim Number

____

Name of Employer

____

Date of Injury

Employee's Signature: ____ **Date**: ______________________

If you have any questions or concerns, please feel free to call Star HRO's Claims department or Loss Control.

Please fax completed form to (844)325-0415 or email to claims@starhro.com