COMPENSATION CLAIMS SOLUTIONS
1287 OLD CHARLOTTE ROAD
CONCORD, NC 28027
PHONE 704-786-9624
FAX – 704-786-9821

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT: _____

DOB: _____

SSN: _____

This authorization or a photocopy thereof, which is unlimited as to time, will authorize you to release to Compensation Claims Solutions or their appointed representative, all information in your possession regarding my medical records.

_____ _____

SIGNATURE **DATE**

Please list the names and address of all physicians who have treated you in the last 5 years.

(Please continue on back if more space is needed)