Commonwealth of Massachusetts
Human Resources Division

Workers' Compensation Section
One Ashburton Place, 3rd Floor
Boston, MA 02108

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

CLAIMANT'S NAME:____

SOCIAL SECURITY #:____

ADDRESS:____

____

TELEPHONE NUMBER:____________________

EMPLOYING AGENCY AND LOCATION: ______________________________

____

DATE OF INJURY: __________________

I am filing a claim for workers' compensation benefits and hereby authorize any hospital or other medical provider to release to the Human Resources Division (HRD), Workers' Compensation Section, ***any and all information relative to my claim for benefits, including, but not limited to, psychiatric records, records pertaining to HIV (AIDS) or other records especially those protected by law.*** I understand that HRD may share this information with my employer, medical and or vocational rehabilitation consultants, utilization review consultants, physicians and other medical care providers and other state agencies involved in the workers' compensation process and I hereby authorize such release to the other persons and entities described.

SIGNATURE:______________________________ DATE:____________________

PLEASE COMPLETE THIS AUTHORIZATION AND RETURN TO:

Human Resources Division
Workers' Compensation Section
One Ashburton Place, 3rd Fl.
Boston, MA 02108

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