



Vocational Rehab Services, Inc.

3230 S. Buffalo Drive, Suite 102, Las Vegas, NV 89117

P: (702) 857-9460 | F: (855) 837-2681

vocationalrehabservices@gmail.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby give authorization for my Workers' Compensation medical provider(s), including physicians, clinics, physical therapists, pharmacies, or other medical and vocational providers, to release medical information and/or medical reports associated with my care to Vocational Rehab Services, Inc., and its authorized representatives.

I acknowledge that such information may indirectly refer to conditions such as medical history, mental health, disorders of the immune system, HIV/AIDS, and other health information.

I also acknowledge that any information received by Vocational Rehab Services, Inc., and its authorized representatives, will be utilized solely for case management purposes, and may be discussed with other professionals involved in the management of my case, such as supervisors, claims examiners, claimant attorneys and/or paralegals (if any), training providers, and government personnel including hearing representatives, judges, and their staff.

This authorization will be good for one year from the date of signature. I also affirm that I may revoke this authorization at any time during this period, by submitting written notice to Vocational Rehab Services, Inc. I also realize that if I were to revoke this authorization, Vocational Rehab Services, Inc., may be unable to provide all authorized vocational rehabilitation services relating to my Workers' Compensation claim.

Print Full Name

Last 4 of SSN

Signature (Patient/Claimant/Injured Employee)

Date Signed