MEDICAL AUTHORIZATION FORM

EMPLOYEE:_____

CLAIM #:_____

TO:_____ **DATE:**_____

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and any other physicians, hospitals, clinic or medical care provider, presently unknown to me, who may have or subsequently acquire information concerning my physical condition.

You are hereby authorized to give to **Guardian Claims Services, Inc.**, or any of its representatives, all information, facts and particulars, including reports, records, results from diagnostic tests, x-rays and statements of charges which may be requested regarding my medical condition, diagnosis, treatment rendered, prognosis, estimates of disability or recommendations for further treatment and to furnish them copies of such reports. You are further authorized to allow any physician appointed by them to review all such reports, records and x-rays in your possession.

I am willing that a photostatic copy of this authorization be accepted with the same authority as the original.

This information is to be used for purposes of evaluating and handling my work related injury, and for no other purpose, now or in the future.

THIS AUTHORIZATION EXPIRES ON CONCLUSION OF CLAIM.

SIGNATURE:_____