



# Medical Administrators, Incorporated

28301 Ranney Parkway Westlake, Ohio 44145  
Phone (440)899-2400 or (800)542-9479 Fax (440)899-2411

## Consent for Medical Release of Information

Date of Injury:  
BWC Claim #:

I, (print name) \_\_\_\_\_, am filing a claim under the Ohio Workers' Compensation Act for a work-related injury that I didn't purposely cause. I understand that I am allowing any doctor that examines or treats me to give all medical information that is related to this claim to the Ohio Bureau of Workers' Compensation, the Ohio Industrial Commission, Medical Administrators and doctors used by Medical Administrators, Inc. and my employer or their representative. I understand that this information will only be used for the management of my work-related injury.

Print Name: \_\_\_\_\_

Sign Name: \_\_\_\_\_

Date: \_\_\_\_\_

In addition, by signing this, I give approval to Medical Administrators, Inc. to talk about my claim with my:

spouse (print name) \_\_\_\_\_

family member (print name & relationship) \_\_\_\_\_

other (print name & relationship) \_\_\_\_\_