



Consent Release of Medical Information

Employee

I hereby authorize representatives of Key HR to be permitted to obtain and review copies of all medical records related to any current or past injury or related to my medical history. Any pertinent information will be discussed with other professionals involved in my medical treatment and any institution that, through the "Workers' Compensation Program" or otherwise, is paying all or part of the costs associated with my medical care.

Employee's Printed Name

Social Security Number

Telephone Number

Claim Number

Name of Employer

Date of Injury

Employee's Signature : _____ Date : _____

Please fax completed form to (888) 252 -5217 or email to risks@KeyHRO.com

If you have any questions or concerns, please feel free to call Key HR's Claims Department or Loss Control.