Ear Nose & Throat Specialties P.C.

WORKERS' COMPENSATION INJURY REPORT

Date of Injury _____

Name of Employer _____

Employer Address _____

Contact Person _____ Phone Number _____

Insurance Carrier _____ Address _____

Phone Number _____ Claim/File Number _____

PATIENT'S AUTHORIZATION

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY WORKERS' COMPENSATION CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

I authorize release of all medical information pertinent to my medical care and necessary to process my workers' compensation claims. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to **Ear, Nose & Throat Specialties, P.C.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I HAVE READ THIS INFORMATION THROUGHLY AND UNDERSTAND IT.

PATIENT/EMPLOYEE _____

DATE _____