MEDICAL AUTHORIZATION

I, , hereby authorize the recipient of this Medical Authorization to release any and all information requested by RCM&D Self-Insured Services Company/SISCO, Workers' Compensation Claims Administrators for my employer, and any and all of their representatives concerning my physical or mental condition and any tests or treatment, which has been rendered to me. I authorize you to provide copies of all medical records, tests, x-rays, reports, or other materials you may have relating to my physical or mental condition on any and all claims. A photocopy of this authorization shall be accepted as an original. This authorization shall remain effective until deemed otherwise by me in the form of written revocation.

Printed Name:

DOB:

SSN:

Claim Number:

Signature: _____

Date Signed: _____