

## City of Melrose - MEDICAL AUTHORIZATION

To be submitted to HR within 24 hours of incident

Employee Name:   X  

Claim Number: \_\_\_\_\_

Date of Injury:   X  

To Provider \_\_\_\_\_ 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 the City of Melrose 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 indemnification claim, and for no other purpose, now or in the future.**

**This Authorization expires on conclusion of claim.**

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

(Please digitally sign or print and sign this document)