MEDICAL AUTHORIZATION AND CONSENT

This will serve as authorization and consent for all health care providers, including but not limited to physicians, nurses, office managers and staff, to release any and all records concerning my medical history, treatment, diagnosis, prognosis, and any other information relating to any injury to Source Logistics, Inc., the insurance company, and/or their representatives/agents that represent Source Logistics, Inc., for the limited purpose of evaluating a Workers' Compensation claim and those medical issues related to any claim. This will further serve as authorization to permit photocopying of any medical records released.

The undersigned additionally grants authorization and permission for all health care providers, including but not limited to physicians, nurses, office managers and staff, to communicate, orally and/or in writing, with Source Logistics, Inc., the insurance company, and/or their representatives/agents that represent Source Logistics, Inc. concerning my medical history, treatment, diagnosis, prognosis, and any other information relating to any injury, upon presentation of this authorization.

A photocopy copy or facsimile copy of this Authorization is specifically authorized by the undersigned, and your cooperating in furnishing the requested information is solicited.

Date: _____

Employee/Patient

Print Name: _____

Signature: _____