Workers Compensation Verification & Consent to Release Medical Records Form

Patient Information

Last Name	*First Name*	*Request Date*
Birth Date		*Date of Injury*
Mailing Address		*Body Part Injured*
City/State/Zip		*Phone Number*

Employer Information

Company Name	*Phone Number*
Owner/Manager Name	*Fax Number*
Mailing Address	Employer Notified? ☐ Yes ☐ No
City/State/Zip	Employer Filed a First Report of Injury? ☐ Yes ☐ No

Worker's Compensation Insurance Information * Required to Bill *

Insurance Company Name	*Phone Number*
Mailing Address	*Claim Number*
City/State/Zip	*Policy Number*
Patient's Personal Representative Name	*Adjuster's Name*

Required Signature

I authorize Lamoille Health Partners to bill and release a copy of my medical records pertaining to my work related injuries to Worker's Compensation Insurance.
***If this form is not returned within seven (7) days of your visit then you and/or your private insurance may be billed for all services provided.*

Signature of Patient ____ Date: ____/____/______

Signature of Patient's Personal Representative ____

For Lamoille Health Partners Internal Use Only

Date Form Received: ____/____/______

Practitioner Signature: _____________________________________ Date: ____/____/______

Completed by: ____ Date: ____/____/______

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