

MEDICAL RELEASE FORM

TO:

I, _____ authorize all medical records pertaining to my injury/accident/illness and any other medical records which my employer may consider significant or in any way related to this incident to be released to the
Workforce Safety and Insurance and NDSCS .

I fully understand that Workforce Safety and Insurance and NDSCS will keep all records fully confidential and will disclose only the necessary information needed in regards to my injury/accident/illness.

Employee Signature _____

Date _____