CMS **ILLINOIS**
DEPARTMENT OF CENTRAL
MANAGEMENT SERVICES

WORKERS' COMPENSATION CLAIM INFORMATION RELEASE AUTHORIZATION ASSOCIATED WITH AN INCIDENT OF:

_____
(Date)

I, the undersigned, do hereby authorize any physician, psychologist, psychiatrist, dentist, hospital or other medical provider to furnish all records, reports, histories, diagnostic tests and evaluation, physician and nurses notes and therapy notes in their possession regarding diagnosis and prognosis for my injuries and opinions regarding the nature, extent, causation, etiology and development of my injuries for the purpose of adjudicating a Workers' Compensation claim to my employer, the State of Illinois or to the Office of the Attorney General. I hereby waive any HIPAA requirements associated with the adjudication and administration of this Workers' Compensation claim. Subject to the terms and limitations set forth herein, I also consent to the use of such information to facilitate efforts of medical case management and rehabilitation/vocational services to assist with my return to work. I also authorize the exchange of information with any state or private entity deemed appropriate by the Claims Section. A photocopy of this authorization shall be considered as effective and valid as the original regardless of the date hereon.

_____
Current Signature

_____
Social Security Number

_____
Witness to Signature

_____
Date

_____
CFN

_____
Date of Injury

_____
Agency/University/Facility

_____
Work Comp Coordinator

CMS 900-5 (R-6/04)