COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

NOTICE OF ONE-TIME CHANGE OF PHYSICIAN & AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Claimant _____ Date of Injury _____

Claimant's Telephone # _____ Insurance Carrier _____

Employer _____ Insurance Carrier Claim # _____

WC# (if applicable) _____

Instructions:

Most employers are required to give an employee a choice of physicians following notification that the employee has been injured on the job. However, some employers are exempt from this requirement. Unless you work for an employer that is exempt from this requirement, you should have been given a written designated provider list containing a list of at least four physicians or corporate medical providers or a combination of both, where available. The designated provider list should also contain the name and contact information of the respondents' representative(s), as well as the name of the insurer or if the employer is self-insured. Unless you work for an employer that is exempt, you are allowed a one-time change of physician, subject to the following requirements:

1. You must complete and sign this form. The form should be filled out as fully as possible with all known information.
2. This form must be provided to the respondents' representative(s) within ninety days after the date of the injury, and before the treating physician has determined maximum medical improvement.
3. The requested new physician is on the designated provider list or provides medical services for a designated corporate medical provider on the list given to you following your injury.
4. You are **not** required to provide this form to the physicians, but may do so.

Current Authorized Treating Physician:

Physician Name _____ Phone # (_____) _____

Address _____
Street Address/PO Box City State Zip Code

Requested Authorized Treating Physician:

Physician Name _____ Phone # (_____) _____

Address _____
Street Address/PO Box City State Zip Code

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

By signing this form I acknowledge that I wish to make a one-time change of physician pursuant to §8-43-404(5)(a)(III) and certify that the information provided in this form is, to the best of my knowledge and belief, true, correct and complete.

I hereby authorize _____ to release medical
(Name and address of current treating physician)

information relating to _____ , _____ on-the-job injury
(Claimant's name) (Date of Injury)

to _____ for purposes of providing medical care under the
(Name and address of requested new treating physician)

Workers' Compensation Act.

I understand that this information may be given to my employer and also may be given to other persons necessary to resolve my claim. All written communications to any physician or health care provider shall be simultaneously provided to me or, if represented, to my attorney.

Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified: _____

Signed: _____ Dated: _____

Print Name: _____

CERTIFICATE OF SERVICE: Copies of this document were placed in the U.S. mail or hand-delivered to the following parties this _____ day of _____ , _____ .
Day Month Year

List the names and addresses of all persons copied:

Respondents' Representative(s): _____

While you are not required to send this form to the physicians, see Instruction No. 4., doing so may result in a smoother transition.

Current Authorized Treating Physician: _____

Requested Authorized Treating Physician: _____

By: _____
Signature