

MEDICAL INFORMATION AUTHORIZATION

TO: _____

DATE: _____

You are hereby authorized and requested to furnish the Claims Investigator of the Ohio Department of Administrative Services or their designee any and all information regarding my physical condition, or regarding any injuries or disease for which I have consulted you or received your services, including the nature of the physical impairment, history, contributing factors, complications, prescriptions, X-rays, copies of hospital or other records, estimates of the period or amount of disability, subjective and/or objective symptoms, diagnosis, prognosis, and any other pertinent information which may be available to you.

Photostatic copy of this authorization shall serve in its stead.

Address

Witness