**Medical Authorization and Release of Confidential Information**

The undersigned person(s) hereby consents to, and by this authorization or any photocopy hereof authorizes, the release to: D.C. OFFICE OF RISK MANAGEMENT or any other agent or employee of the D.C. Office of Risk Management of any and all medical reports, histories, findings, prognosis, bills, information and other documentation relating to any medical treatment or services, including psychiatric treatment or treatment for alcoholism and/or drug abuse. This release also authorizes the release of any and all documented employment history, personnel records, and any other documentation concerning me personally that will assist the representative in evaluating my claim for benefits under the D.C. Workers Compensation Act for Government employees.

I understand and hereby acknowledge that the information above or certain portions thereof, may be protected from disclosure without this signed Authorization by federal and state privacy and confidentiality laws.

This authorization shall expire automatically without express revocation at such time as my claim for benefits expires and/or is revoked, denied and/or terminated.

**Printed Name:**

**Social Security #:**

**Claim Number:**

**Date of Injury:**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form 7.1-040, Rev 4