DZNPS Workers' Compensation Administration Office
2211 Quarry Drive, Suite E-58B
West Lawn, PA 19609
1-888-213-1043
FAX: 1-888-213-1054

DATE _____

MEDICAL INFORMATION RELEASE AUTHORIZATION
REGARDING WORKER COMPENSATION CLAIMS

TO WHOM IT MAY CONCERN:

IN THE EVENT OF A WORK RELATED INJURY, WHILE EMPLOYED BY DAY & ZIMMERMANN NPS, INC., I HEREBY AUTHORIZE ANY LICENSED PHYSICAN, MEDICAL PRACTITIONER, HOSPITAL, CLINIC OR MEDICALLY RELATED FACILITY THAT HAS MY MEDICAL RECORDS TO DISCLOSE COPIES OF SAID RECORDS TO DAY & ZIMMERMANN NPS, INC. OR ITS AUTHORIZED WORKMEN'S COMPENSATION INSURANCE CARRIER. A PHOTOSTATIC COPY OF THE EMPLOYEES AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

THIS AUTHORIZATION SHALL NOT BECOME EFFECTIVE UNLESS AND UNTIL THE UNDERSIGNED EMPLOYEE HAS FILED A WORKMEN'S COMPENSATION CLAIM.

(SIGNED)_____

(S.S. NO.)_____

(ADDRESS)_____