SPOONER MAI
Spooner Medical Administrators, Inc.
28301 Ranney Parkway
Westlake, Ohio 44145

urac
ACCREDITED
CASE MANAGEMENT

Consent for Medical Release of Information

Date of Injury:
BWC Claim #:

I, (print name) _____, am filing a claim under the Ohio Workers' Compensation Act for a work-related injury that I didn't purposely cause. I understand that I am allowing any doctor that examines or treats me to give all medical information that is related to this claim to the Ohio Bureau of Workers' Compensation, the Ohio Industrial Commission, Spooner Medical Administrators and doctors used by Spooner Medical Administrators, Inc. and my employer or their representative. I understand that this information will only be used for the management of my work-related injury.

Print Name: _____

Sign Name: _____

Date: _____

In addition, by signing this, I give approval to Spooner Medical Administrators, Inc. to talk about my claim with my:

spouse (print name) _____

family member (print name & relationship) _____

other (print name & relationship) _____