COMMUNITY HEALTH SERVICES
OF LAMOILLE VALLEY®

Workers Compensation Verification & Consent to Release Medical Records Form

Patient Information	
Patient Name:	Request Date:
Birth Date:	**Date of Injury:**
Mailing Address:	**Body Part Injured:**
City/State/Zip:	Telephone #:
Employer Information	
Company Name:	Telephone Number:
Owner/Manager Name:	Fax Number:
Mailing Address:	Employer Notified? ☐ Yes ☐ No
	Employer Filed a First Report of Injury? ☐ Yes ☐ No
Worker's Compensation Insurance Information *Required to Bill*	
Insurance Company Name:	Telephone Number:
Mailing Address:	Claim Number:
City/State/Zip:	Policy Number:
Patient's Personal Representative Name:	Adjuster's Name:

REQUIRED SIGNATURE

I authorize Copley Professional Services Group (CHSLV) to bill and release a copy of my medical records pertaining to my work related injuries to Worker's Compensation Insurance.
***If this form is not returned within seven (7) days of your visit then you and/or your private insurance may be billed for all services provided*.**

Signature of Patient _____ Date: ____/____/___

Signature of Patient's Personal Representative_____

FOR CHSLV INTERNAL USE ONLY

Date Form Received: _____

Practitioner Signature: _____ Date: ___/_____/___

Completed by: _____ Date: ___/____/____