Ohio | Bureau of Workers' Compensation

Authorization to Release Information

Injured worker

Name	Date of birth	Claim number	
Address			
City	State	ZIP code	Phone number

Records requestor

Name	Business name CEFARATTI GROUP	
Address 4608 ST. CLAIR AVENUE		
City CLEVELAND	State OHIO	ZIP code 44103
Phone number 216.696.1161	Fax number 216.912.0001	E-mail address recordsinfo@cefgroup.com

Specific Information Authorized

☐ I authorize BWC to disclose to the above-named individual and/or organization, records, information and/or data (selected below) regarding **any and all** of my BWC claims.

☐ I authorize BWC to disclose to the above-named individual and/or organization, records, information and/or data (selected below) regarding the following BWC claim(s):

_____

☐ Complete claim file(s)
☐ Claim status
☐ Industrial Commission of Ohio orders
☐ Medical records
☐ Wages/payments
☐ Medical billing history
☐ Other _____

By signing below, I represent that I have the authority to sign this document, and I acknowledge the following:

- I understand the information included in my health and medical records may include sensitive information related to private health matters;
- I understand BWC does not control the use of the released information once it has been disclosed to a recipient; any disclosure of information creates the potential for an unauthorized re-disclosure by the recipient; and that BWC expressly denies any liability for any consequences arising out of such disclosure;
- I understand this authorization is only valid for one year from the date of signature;
- I further understand I have a right to revoke this authorization at any time;
- I understand I can refuse to sign this authorization, and I further acknowledge that I have executed this authorization voluntarily and by my own free will.

Signature of injured worker (or legal guardian, authorized representative, or executor, where applicable)	Date