AUTHORIZATION FOR THE RELEASE OF MEDICAL/EMPLOYMENT RECORDS

I, _____
Claimant and/or Patient

SS #: _____ DOB: _____

Hereby grant permission to and authorize any and every physician; medical practitioner; hospital; clinic; health dispensary or facility; provider of health care; insurance or reinsurance company; employer; educational institution; governmental agency, whether it be Federal, State or Local; to allow these designated entities:

North Orange County Community College District Risk Manager, Southern California Risk Management, Inc. and/or its employee, agent, copy service, legal representative, attorney, professional medical examiner or evaluator:

To review, inspect, copy and/or photocopy any and all of the following in your possession or control:

> **x-rays, films and reports; medical, physiological, psychological and psychiatric substance abuse, and/or rehabilitation, records, charts, notes and letters; personnel, attendance, employment, payroll and wage records of my employer or schools.**

The above information is being obtained to assist said authorized entities in evaluating my claim for benefits or damages.

I understand and have been informed that I have a right to receive a copy of this authorization and I hereby acknowledge receipt of a true copy of this medical release.

This authorization is valid for three years from the date it is signed by me.

Dated: _____ Signed: _____
Claimant and Patient

A photocopy, thermo fax, or carbon copy of this original is to be treated as an original.

Evidence Code: Section 1158
"Failure to make such records available, during business hours, within five days after the presentation of the written authorization, may subject the person or entity having custody or control of the records to liability for all reasonable expenses, including attorney's fees, incurred in any proceeding to enforce the provisions of this section."