P.O. Box 32036, Lakeland, FL 33802-2036

NOTICE OF PHYSICIAN CHOICE & MEDICAL AUTHORIZATION

Claimant's Name: _____
Claimant's SS #: _____
Employer's Name: _____
Injury Date: _____
MWCC #: _____

I am claiming to have sustained an injury involving my _____

□ I am □ I am no claiming that my medical condition is work-related.

If work related:

I understand that by the Mississippi Workers' Compensation Act I have the right to choose one physician to render treatment to me. I can either accept the physician to whom I am sent by my employer or choose someone else on my own.

I also understand that my one chosen physician must make any referral to any other doctor.

I also understand that my employer (or workers' compensation carrier) must approve any physician change, and that if I change doctors without their authorization, I will be responsible for the medical expenses for the unauthorized treatment:

With that understanding, I state as follows:

□ I accept as my choice of employer's tender of treatment by Dr. _____.

□ I elect to choose my own physician to render treatment, and that choice is Dr. _____.

I also hereby authorize any doctor, physician, psychologist, hospital, or other provider of medical and related care to release unto and/or discuss with my employer, their agents, employees, workers' compensation insurance carrier, third party administrator, or attorneys, all medical information including reports, psychological test results, opinions, records, x-rays, x-ray reports, laboratory reports, nurses' notes, physicians' orders, and any and all other documents relating to any examination or treatment of myself.

I hereby agree that a copy of this authorization form shall have the same force and effect as the original thereof and further agree that this authorization shall remain valid so long as the claim against my above named employer is pending.

_____
Claimant's Name

Date: _____

Witnessed By:

_____

_____

Original – Employer's File
Copy – Employee
Copy – Carrier/Third Party Administrator

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