CopperPoint Insurance Companies

Phone: 602.631.2288
Toll Free: 1.800. 416..3863
Fax: 602.631.2888
Toll Free Fax: 1.800.356.4867

3030 N 3rd Street | Phoenix AZ | 85012-3068

copperpoint.com

Date

Claimant Name		
Date of Loss	Carrier No.	W.C. No.
Employer		

Dear Claimant Name:

Please provide your five-year medical history below, sign and complete the Medical Authorization to Release Information form, and return both documents to us at the address listed above.

Provider Name	Provider Address and Phone	Year treated	Treatment received

If additional space is needed, please attach a separate piece of paper and return with this letter.

Sincerely,

Name
Job Title
Additional Contact Info

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Claimant: _____ Claim No.: _____

Social Security No.: _____ Date of Birth: _____

AUTHORIZATION TO RELEASE INFORMATION

By this authorization or reproduction thereof, I hereby authorize and request any person or organization to allow the above referenced carrier or its authorized representative to examine, discuss and copy any information, records, reports and x-rays regarding my medical condition, treatment and employment history.

Disclosure of medical records for the purpose of administration of workers' compensation claims is authorized by the Health Insurance Portability and Accountability Act (HIPAA), § 45 C.F.R. § § 164.512.

Date: _____

Claimant's Signature: _____

Address: _____
(Street, City, State, Zip Code)